

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155417	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/30/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT SCOTTSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N GARDNER AVE SCOTTSBURG, IN 47170
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29, and 30, 2012</p> <p>Facility Number: 000421 Provider Number: 155417 AIM Number: 100288340</p> <p>Survey Team: Jill Ross, RN, TC Diana Sidell, RN Gloria Riesert, MSW</p> <p>Census Bed Type: SNF/NF: 33 Total: 33</p> <p>Census Payor Type: Medicare: 2 Medicaid: 26 Other: 5 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 6, 2012 by Bev Faulkner, RN</p>	F0000	<p><b>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Scottsburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on December 30, 2012.</b></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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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure a resident had an intravenous (IV) inserted timely, received ordered fluids for increased hydration and failed to monitor the resident's intake and output prior to and after the IV for 1 of 1 resident reviewed for hydration. (Resident #10)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #10 on 11/28/12 at 9:00 a.m., indicated the resident was re-admitted to the facility from the hospital on 8/30/12 and had diagnoses which included, but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, asthma, depression and insulin dependent diabetes mellitus.</p> <p>Review of the Nursing notes between 8/30/12 and 9/14/2012 indicated the following entries:</p> <ul style="list-style-type: none"> <li>- "8/31/12 3P - res c/o [complained of] nausea and small amt vomiting, Phenergan given and MD notified.</li> <li>- 5 p breath sounds with wheezing</li> </ul>	F0327	<p><b><u>F327</u></b> It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health, including making sure that intravenous fluids are administered as ordered and that residents who receive intravenous fluids will have their intake and output monitored.</p> <p><b><u>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b> Resident #10 is no longer a resident of this facility. The DON has re-educated the licensed nurses on 12-18 -12 on measuring and documenting intake and output, as well as implementing physician orders in a timely manner. <b><u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u></b> No other residents have received intravenous fluids and been affected by this practice. However, if the DON should identify any concerns related to any resident receiving intravenous fluids in the future, she will intervene at that time to make sure that the resident is receiving intravenous fluids as</p>	12/30/2012

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	<p>and some SOA [shortness of air] upon talking, o2 placed.</p> <p>- 6:30 p - N.O. for Zofran 4 mg q 6 hours PRN N/V and Xanax</p> <p>- 8 P - drank small amounts of liquids only. No N/V.</p> <p>- 10:30 p - N.O. to resume Lasix and Aldactone"</p> <p>- "9/1/12 7 P - Cont to c/o nausea but no vomiting, did take diet coke, refused sprite. Has facial edema but has improved today."</p> <p>- "9/3/12 7 P - no nausea or vomiting today and appetite has improved."</p> <p>- "9/5/12 7:10 P - res noted with very poor appetite still, very poor intake MD notified and new orders for labs obtained."</p> <p>- "9/6/12 10:30 am - Nausea at times.</p> <p>- 7P - resident gagging and c/o nausea, Phenergan given IM</p> <p>- 7:30 p - no further nausea"</p> <p>- "9/7/12 6 P - res with green slimy stool - MD notified with N.O. for c-diff culture."</p> <p>- "9/9/12 1:15 pm - res vomiting approx 100 cc undigested food/stomach contents. Phenergan IM.</p>		<p>ordered by the physician and that the staff is measuring the intake and output of that resident. When the resident is taken care of, the DON will review the facility policy regarding the initiation of intravenous fluids and the need to measure intake and output. The DON will also render progressive disciplinary action for continued noncompliance in this area as deemed appropriate at that time. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b> The Director of Nursing/Designee will review physician orders at least five days a week for the next 90 days to ensure intake and output is measured and documented as appropriate per policy, and that physician orders are implemented timely. The DON or Designee will bring copies of the physician telephone orders to the Clinical Meeting at least 5 days per week for review and discussion by the interdisciplinary team. Any recommendations made by the interdisciplinary team will be followed through by the DON or designee who will report the status of those recommendations at the next scheduled clinical meeting. Any identified issues will be dealt with as indicated in question #2. <b><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA</u></b></p>				

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	<p>- 1:50 pm - no further n/v noted."</p> <p>- "9/10/12 11 p - Had taken part of evening meds. Began to vomit. Vomited approximately 200 cc dark colored liquid. Phenergan 25 mg IM. - 2:25 pm - Culture results + for C-diff. - Cipro and Flagyl ordered"</p> <p>- "9/11/12 7 p.m., no nausea and vomiting this shift; appetite remains poor, fluids encouraged with fair results, loose stools x 1"</p> <p>- "9/12/12 10 am - res had emesis x 1 this shift. Large amount noted. - 7 P MD notified and ordered Pharmacy to place PICC line and start ATB IV and run 1/2 N/S at 50 cc hr continuous for hydration"</p> <p>Review of an MD telephone order, dated 9/12/12, indicated the order was written as "[name of pharmacy] to place a PICC line with FU [follow-up] xray (portable). Then - D/C po Cipro &amp; Flagyl - Give Flagyl 500 mg TID &amp; Cipro 500 mg BID, 1/2 NS [normal saline] cont [continue] at 50 cc hr. BMP [Basal Metabolic Profile-lab tests] in AM. Follow Nursing Home PICC Care"</p> <p>On 9/13/12, an MD telephone order indicated "order clarification - Cipro &amp;</p>		<p><b><u>will be put into place?</u></b> The results of these reviews will be brought to the monthly QA meeting for 3 months for further review and recommendations for process improvement. The QA committee will determine the continued frequency of the review after the 3 month time period has elapsed and when the facility has demonstrated 100% compliance. Even when the written reviews are stopped, the DON will continue the review process of physician orders as indicated in #3 on an ongoing basis. <b><u>Date of Compliance:</u></b> 12/30/12</p>				

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	<p>Flagyl to be IV. Send STAT)"</p> <ul style="list-style-type: none"> <li>- "9/13/12 MD T.O. [telephone order] indicated "BMP in am [sic]; increase 0.45 NS to 75 cc Hr cont"</li> <li>- 7:15 p - res drank milk at supper but no food intake.</li> <li>- 9 P Pharmacy notified of N.O.."</li> </ul> <p>Documentation was lacking of why the PICC line placement was not going to be started until 9/13 instead of 9/12.</p> <ul style="list-style-type: none"> <li>- "9/13/12 3 A - res was nauseated earlier and was given Phenergan - effective at this time.</li> <li>- 9 A nurse here to place PICC line; placement verified at 1 pm.</li> <li>- 4 P - Picc line is patent &amp; flushes easily with good blood return. 0.45 NS started as ordered, awaiting Flagyl from Pharmacy, to do STAT delivery.</li> <li>- 6 P Flagyl infusing IV at this time.</li> <li>- 7 P Cipro started IV PICC remains patent and free from any s/s of infiltration"</li> </ul> <p>September 2012 Resident Fluid and Meal Percentage Intake Log indicated:</p> <p>9/1 - 9/7 - breakfast was resident's best meal with usual 100% intake food and 240 ccs fluid; lunch with</p>			

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	<p>poor food intake (0% most times) and 120 ccs fluid, supper with 10% food and 120 cc fluids; 120 ccs fluids consumed between meals.</p> <p>9/8 to 9/13 - usual 0 % food intake for breakfast with varying fluid intake between 0-120 cc; lunch usual 15-20% food intake with 240 cc fluid; and supper was usual 20% food intake with varying intake of fluids; frequent 0% intake of fluid between meals</p> <p>A 9/13/12 Episodic Care Plan IV Therapy was written - "Requires Paternal Fluids R/T: Nausea/Vomiting &amp; Diarrhea - PICC line Lt arm"; Approaches included but were not limited to: Administer IV as ordered - 0.45 NS at 75 cc hr; Monitor intake and output."</p> <p>8/31/12 and 9/13/12 Episodic Care Plans Dehydration (Includes nausea, vomiting, and/or diarrhea) Approaches included, but were not limited to: "Monitor intake and output every shift; Offer and encourage po fluids to as tolerated cc in 24 hours"</p> <p>Documentation was lacking of the resident's intake and output being monitored once the IV was inserted.</p>			

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	<p>On 11/29/12 at 12:05 p.m., the Corporate Nurse presented a copy of the facility's current policy on "Intake and Output Measurement." Review of the policy at this time included, but was not limited to: "Purpose: To maintain an accurate record of the resident's fluid balance...Guidelines: The following residents require measurement and documentation of intake and output at the end of every shift, including a 24 hour total:...All residents receiving intravenous feeding...Procedure:...4. If any bleeding, emesis or diarrhea occur, measure and record as output. 5. When enternal nutritional therapy or intravenous fluid is administered, record amount on individual record. 6. The intake is to be totaled and recorded on the permanent intake and output record..."</p> <p>An 11/29/12 at 1:45 p.m., interview with the Acting DON and Corporate RN indicated "We knew there was an issue with the I &amp; O (intake and output)not being started on the resident like it should have been - wasn't even marked on the TAR like it should have been of how much fluids were being infused in 24 hours period. Only recorded on the meal intake record. During chart review, noticed the conflict between the Cipro</p>			

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	<p>and Flagyl being PO or IV - did not realize there was such a delay in starting the fluids and meds. Resident has such poor venous access, not sure if that was why the PICC line was not put in- failed to get it, but there should have been documentation of why the meds were delayed and why the IV was not started until the next day."</p> <p>3.1-46(b)</p>			

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F0329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></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>A. Based on record review and interview, the facility failed to ensure one resident's drug regimen was free of psychotropic medications used for excessive duration without a gradual dose reduction (Resident #17). This deficient practice affected 1 of 10 residents reviewed for unnecessary medications.</p> <p>B. Based on record review and interview, the facility failed to ensure a resident's medication had an</p>	F0329	<p><b>F329</b> It is the policy of this facility that each resident's drug regimen is free from unnecessary drug, including psychotropic medications that are not used in excessive dose without a gradual dosage reduction or without indications for use. <u><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></u> For Resident #17, the attending physician was contacted. He wrote a progress note that provided sufficient</p>	12/30/2012

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	<p>adequate indication for use in that a medication ordered for temperature was given for pain (Resident #15). This affected 1 of 10 residents reviewed for unnecessary drugs.</p> <p>Finding includes:</p> <p>A.1. Clinical record review on 11/30/12 at 8:55 a.m., for Resident #17 indicated the resident was admitted on 11/1/10 and re-admitted on 1/24/11 from the hospital. Diagnoses included, but were not limited to: status post cerebral vascular accident, anxiety, dementia with agitated features, and depression.</p> <p>On 5/16/12, the consultant pharmacist made a recommendation for consideration of decreasing the resident's Risperdal [an anti-psychotic medication] use from 1 mg BID (twice a day) to 1 mg in A.M. and 0.5 mg at HS (hours of sleep) as the resident was receiving hospice services and exhibited very minimal behaviors, none of which were psychotic.</p> <p>The Risperdal was ordered on 10/20/11 for dementia with psychotic features.</p> <p>The MD responded back on 6/14/12</p>		<p><u>rationale for not attempting a gradual dose reduction of the Risperdal. For Resident # 15, the attending physician was notified on 11-29-12 for clarification of the Acetaminophen order. New orders were received to revise the order and include the use of the medication for pain or fever. The DON will inservice all nurses regarding the use of medications as indicated on 12-18-12. The DON will train the IDT team on 12-17-12 regarding gradual dose reductions and the documentation required for clinical contraindication of dosage reduction 2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? </u>The DON has reviewed all physician orders for appropriate indication of use and for evidence of gradual dose reductions where indicated – this was completed on 12/11/12. No other residents were found to be affected by this practice. If, in the future, the DON finds that medications are not being used as indicated or that gradual dose reductions are not occurring as required, she will follow up with the attending physician. Once that is done, she will review the facility policy for medications and indications for use with the nurses. The IDT will also receive retraining done by the DON or Administrator regarding the timing</p>		

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	<p>and indicated that he disagreed "due to comfort measures was 1 hour goal. GDR [gradual dose reduction] would likely cause worsening."</p> <p>On 10/30/12, the Consultant Pharmacist made a recommendation again for consideration of decreasing the resident's Risperdal use from 1 mg BID to 1 mg in A.M. and 0.5 mg at HS as the resident was receiving hospice services and exhibited very minimal behaviors, none of which were psychotic.</p> <p>On 10/31/12, the primary MD responded back and indicated that he refused to consider the recommendation. No reasoning was given for the refusal. The primary MD also saw the resident that day, but no reference was made to the reduction request.</p> <p>On 11/30/12 at 10:30 a.m., an interview with the Social Worker indicated that the resident had occasional agitation and that she had asked hospice to address the issue of the psych meds in their notes.</p> <p>Review of the 11/29/12 Hospice Nurses Visit Note made a reference: "Behavior Med reduction contraindicated for this pt r/t</p>		<p>and documentation of gradual dose reductions for psychotropic drugs. Continued noncompliance will be addressed through the progressive disciplinary system as deemed appropriate. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b> The Director of Nursing/Designee will review physician orders five days a week for 90 days to ensure medications have appropriate indications for use listed on the order. These orders will also be reviewed by the interdisciplinary team (IDT) at the Daily Clinical Meeting which is held at least five times per week. Any recommendations made by the interdisciplinary team will be followed through by the DON or designee who will report the status of those recommendations at the next scheduled clinical meeting. Any identified issues will be dealt with as indicated in question #2. All residents receiving psychotropic medications will be reviewed monthly by the interdisciplinary team. All residents who have not had a gradual dosage reduction of psychotropic medications per the federal regulation will be identified at that time. Each physician will be notified of the need for a drug reduction. If the physician believes that there is a clinical contraindication for reducing the drug, he/she will be</p>	

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	<p><b>Dementia and hospice services."</b></p> <p>Review of the Hospice nursing, spiritual counselor, social work and CNA notes between 10/1/12 and 11/29/12 failed to indicate the resident had exhibited any behavior issues during their visits. Nursing and CNA did make reference to the 11/28/12 facility note regarding the resident being combative with care due to the need to have a BM, but that after wards, the resident was in a better frame of mind.</p> <p>On 11/30/12 at 11:25 a.m., the Acting DoN presented the facility's current policy on "Medication - Unnecessary." Review of the policy at this time included, but was not limited to: "Policy: 1. Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used:...for excessive duration...2. Based on comprehensive assessment of a resident, this facility will ensure that:...Residents who use anti-psychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs...3...Each resident receives only those medications in dose and for the</p>		<p>asked to document that rationale in the resident's clinical record. During subsequent reviews, the IDT will review each of these records to ensure there is documentation evident to indicate sufficient rationale to clinically contraindicate the reduction or that an order has been received to reduce the drug's dosage. <b>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The results of the reviews will be brought to the monthly QA meeting for 3 months for further review and recommendations. The QA committee will determine the continued frequency of the review after the 3 month time period once the facility has demonstrated 100% compliance. However, the review process at the clinical meetings and the monthly psychotropic drug review will continue on an ongoing basis. <b><u>Date of Compliance:</u></b> 12/30/12</p>	

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	<p>duration clinically indicated to treat the resident's condition(s)...Tapering Of A Medication Dose/Gradual Dose reduction (GDR): The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original symptoms has resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms...For residents who are receiving an anti-psychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and The physician has documented the clinical rationale for why an additional attempt dose reduction at that time would be likely to impair the resident's function or increase distressed behavior..."</p> <p>B.1. Resident #15's record was reviewed on 11/28/12 at 1:55 p.m. The record indicated Resident #15 had diagnoses that included, but were</p>			

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	<p>not limited to, left sided weakness, recurrent depressive psychosis, convulsion, recurrent urinary tract infection, gastroesophageal reflux disorder, traumatic brain injury, difficulty swallowing, seasonal allergies.</p> <p>Physician's recapitulation orders, dated November 1 through November 2012, indicated an order for acetaminophen 325 milligrams, 2 tablets (650 milligrams) by gastrostomy tube every 6 hours as needed for fever &gt; (greater than) 101, with a start date of 7/25/12.</p> <p>October 2012 Medication Administration Records (MARS) indicated the acetaminophen had been given eleven times during October for complaints of headaches, back pain, or left shoulder pain.</p> <p>November 2012 MARS indicated the acetaminophen had been given eight times during November for complaints of headache, back pain, or left shoulder pain.</p> <p>During an interview on 11/30/12 at 11:45 a.m., the Director of Nurses indicated this order should have been clarified and that it was written for fever.</p>			

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	<p>A policy and procedure for "Medication Monitoring and Management" was provided by the Minimum Data Set Coordinator on 11/30/12 at 11:00 a.m. The policy indicated, but was not limited to: "In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use...5...b. A written diagnosis, an indication, and/or documented objective findings support each medication...6) As needed (PRN) orders include an indication for use...."</p> <p>3.1-48(a)(2) 3.1-48(a)(4) 3.1-48(b)(2)</p>				

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to ensure residents' medications were ordered in a timely manner to ensure medications were available for administration for 1 of 10 residents reviewed for unnecessary medications. (Residents #20)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #20 on 11/28/12 at 9:53 a.m., indicated the resident had diagnoses which included, but was</p>	F0425	<p><b>F425</b> It is the policy of this facility to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement in a timely manner. <b><u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 11-28-12 the medications, including eye drops, were reviewed for resident #20 and a sufficient supply was available. The DON will provide inservice training for the nurses/QMAs regarding the timeliness of ordering and obtaining meds from outside pharmacies? Training on circling</u></b></p>	12/30/2012	

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	<p>not limited to: coronary artery disease, arthritis, osteoporosis, psychosis, atrial fibrillation, hypertension, cataracts, dementia with behavior disturbances, depression, and anemia,</p> <p>A Nursing Note, dated 10/9/12, indicated "Per res [resident] and dtr [daughter] request - Artificial Tears requested to be made routine - N.O. [new order] received."</p> <p>Review of the 2012 October Medication Administration Record [MAR] indicated the resident had the following doses of medication circled with no explanation on back of MAR as to why med was not given:</p> <p>a. Aspirin 325 mg (ordered 3/15/10) - not given on 10/9 before breakfast dose; 10/28 and 10/29 before breakfast dose.</p> <p>A 10/29/12 Nursing Note at 7:00 a.m., indicated the pharmacy was faxed at this time for refill of the Aspirin.</p> <p>b. Artificial Tears (ordered 10/9/12 as routinely administration) - not given the 10/20 evening dose, 10/21 before breakfast and evening dose, 10 /22 before breakfast dose.</p>		<p><u>medications and writing explanation on the back of the MAR will also be included.</u></p> <p><b><u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u></b> An audit of the medication cart done was done on 11-28-12. All residents were found to have all medication available as ordered by the physician. No other residents were affected by this practice. If the DON or designee finds that medication is not available at any time in the future, she will follow up with the pharmacy and family to make sure that the medication is obtained as quickly as possible. If she finds that medication doses are circled on the front of the MAR without explanation on the back of the MAR, she will follow up with the nurse(s) involved to find out the reasons for the circles and lack of documentation. She will review the facility policy with all the nurses/QMAs involved regarding the timeliness of obtaining medications from outside pharmacies and the proper documentation of doses that are not given to residents. She will institute progressive disciplinary action for continued noncompliance in this area. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient</u></b></p>	

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	<p>A 10/20/12 Nursing Note at 4:00 p.m., indicated the resident's daughter was with the resident that afternoon and was notified that the facility did not have the eye drops in yet from the pharmacy. Order was again faxed to the pharmacy and the facility would let the daughter know when they came in.</p> <p>On 11/29/12 at 12:05 p.m., the Corporate RN presented a copy of the facility's current policy on "Medication Ordering and Receiving From Pharmacy." Review of the policy at this time included, but was not limited to: "Policy: Medications and related products are received from the dispensing pharmacy on a timely basis...Procedures:...2...a) Reorder medication three to four days in advance of need to assure an adequate supply is on hand...."</p> <p>On 11/29/12 at 1:45 p.m., during an interview with Acting DoN and Corporate RN, they indicated, "We noticed when reviewing the chart that there were circles on meds but no explanation of why not given. There should have been. Yes, our policy does explain that, too. Cannot explain why meds were not ordered in time or why there was a delay in getting the</p>		<p><b><u>practice does not recur? A</u></b> worksheet labeled Outside Pharmacy Checklist was implemented on 11-29-12 to track when medications are ordered from outside pharmacies and when they are delivered. The Director of Nursing/Designee will review the list every Monday and verify that medications are available. The DON will review each MAR at least 3 times a week for the next month, then at least weekly for the following 60 days, for any circled doses and documentation of the reason for the circled doses on the back. If the DON identifies any issues as a result of her reviews, she will follow up as indicated in question #2. <b><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The Director of Nursing/Designee will bring the results of the reviews to the monthly QA meeting for review and further recommendations. This reporting will continue for the next 3 months. The QA committee will determine the continued frequency of the review after the 3 month time period has elapsed and the facility has demonstrated 100% compliance. However, the review process will continue on an ongoing basis. <b><u>Date of Compliance:</u></b> 12/30/12</p>		

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	<p>meds resulting in meds not being given."</p> <p>3.1-25(a) 3.1-25(g)(2) 3.1-25(g)(3) 3.1-25(k)(5)</p>			

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F0428 SS=D	<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 record review and interview, the facility failed to ensure the physician provide a sufficient rationale for not attempting a gradual dose reduction on the resident's psychotropic medication per the pharmacist's recommendation for 1 of 10 residents reviewed for unnecessary medications. (Resident #17)</p> <p>Finding includes:</p> <p>Clinical record review on 11/30/12 at 8:55 a.m., for Resident #17 indicated the resident was admitted on 11/1/10 and re-admitted on 1/24/11 from the hospital. Diagnoses included, but were not limited to: status post cerebral vascular accident, anxiety, dementia with agitated features, and depression.</p> <p>On 5/16/12, the consultant pharmacist made a recommendation for consideration of decreasing the</p>	F0428	<p><b>F428</b> It is the policy of this facility to ensure the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist. <b><u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b> For Resident #17, the attending physician was contacted. He wrote a progress note that provided sufficient rationale for not attempting a gradual dose reduction of the Risperdal. The Director of Nursing will train the IDT team on 12-18-12 regarding gradual dose reductions and the documentation required for clinical contraindication of dosage reduction. <b><u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u></b> A review of resident's receiving psychotropic medications was completed on 12-11-12. No other resident were found to be affected by this deficient practice. The DON has</p>	12/30/2012	

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	<p>resident's Risperdal [an anti-psychotic medication] use from 1 mg BID (twice daily) to 1 mg in A.M. and 0.5 mg at HS (hours of sleep) as the resident was receiving hospice services and exhibited very minimal behaviors, none of which were psychotic.</p> <p>The Risperdal was ordered on 10/20/11 for dementia with psychotic features.</p> <p>The MD responded back on 6/14/12 and indicated that he disagreed "due to comfort measures was 1 hour goal. [sic] GDR [gradual dose reduction] would likely cause worsening."</p> <p>On 10/30/12, the Consultant Pharmacist made a recommendation again for consideration of decreasing the resident's Risperdal use from 1 mg BID to 1 mg in A.M. and 0.5 mg at HS as the resident was receiving hospice services and exhibited very minimal behaviors, none of which were psychotic.</p> <p>On 10/31/12, the primary MD responded back and indicated that he refused to consider the recommendation. No reasoning was given for the refusal. The primary MD also saw the resident that day, but no reference was made to the reduction</p>		<p>reviewed all physician orders for evidence of gradual dose reductions where indicated – this was completed on 12/11/12. No other residents were found to be affected by this practice. If, in the future, the DON finds that medications without evidence of gradual dose reductions are occurring as required, she will follow up with the attending physician. Once that is done, the IDT will receive retraining done by the DON or Administrator regarding the timing and documentation of gradual dose reductions for psychotropic drugs. Continued noncompliance will be addressed through the progressive disciplinary system as deemed appropriate. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b> All residents receiving psychotropic medications will be reviewed monthly by the interdisciplinary team. All residents who have not had a gradual dosage reduction of psychotropic medications per the federal regulation will be identified at that time. Each physician will be notified of the need for a drug reduction. If the physician believes that there is a clinical contraindication for reducing the drug, he/she will be asked to document that rationale in the resident's clinical record. During subsequent reviews, the IDT will</p>				

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	<p>request.</p> <p>On 11/30/12 at 10:30 a.m., an interview with the Social Worker indicated the resident had occasional agitation and that she had asked hospice to address the issue of the psych meds in their notes.</p> <p>On 11/30/12 at 11:25 a.m., the Acting DoN presented the facility's current policy on "Medication - Unnecessary." Review of the policy at this time included, but was not limited to: "Policy: 1. Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used:...for excessive duration...For residents who are receiving an anti-psychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and the physician has documented the clinical rationale for why an additional attempt dose reduction at that time would be likely to impair the resident's function or increase distressed behavior..."</p> <p>3.1-25(i)</p>		<p>review each of these records to ensure there is documentation evident to indicate sufficient rationale to clinically contraindicate the reduction or that an order has been received to reduce the drug's dosage. If the physician has not provided sufficient rationale, the DON and Administrator, and/or the Medical Director, will follow up with the attending physician in question to obtain the necessary documentation. <b><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The results of the reviews will be brought to the monthly QA meeting for 3 months for further review and recommendations. The QA committee will determine the continued frequency of the review after the 3 month time period once the facility has demonstrated 100% compliance. However, the review process at the clinical meetings and the monthly psychotropic drug review will continue on an ongoing basis.</p> <p><b><u>Date of Compliance:</u></b> 12/30/12_</p>		

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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review, interview and observation, the facility failed to ensure medications and medical care items were labeled when opened and</p>	F0431	<b>F431</b> It is the policy of this facility to ensure medications and medical care items are labeled when opened and discarded when expired. <u>1. What</u>	12/30/2012			

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	<p>discarded when expired. This was found during 1 of 1 medication cart check and 1 of 1 treatment cart check and 1 of 1 medication room check. This affected 5 out of 33 residents who received medications from the facility. (Residents #6, 13, 15, 31, and 34)</p> <p>Findings include:</p> <p>During the check of the medication room on 11/29/12 at 10:37 a.m., with the acting Director of Nursing, the counter was full of boxes and packs of drinks. The room was in disarray. There were two bottles of Milk of Magnesia that were not opened with expiration dates of 7/1/11 for Resident #6 and 10/24/12 for Resident #34.</p> <p>On 11/29/12 at 1:36 p.m., the treatment cart was checked with LPN #1. There was Canterbury Mixture for Resident #13 that was opened, but had no open date. There was anti-dandruff shampoo for Resident #15 with no opened date. There were two bottles of Wound and Skin Cleanser opened, not dated, and no resident's name on them.</p> <p>11/30/12 at 8:20 a.m., the medication cart was checked with the acting</p>		<p><b><u>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b> The medications for resident # 6, 13, 15, 31 and 34 were discarded immediately and re-ordered from the pharmacy. Re-education was provided to the nurses/QMA's on 12-18-12 regarding dating medications when opened and discarding expired medications. <b><u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u></b> An audit of the medications and biologicals has been completed. There were no other residents affected by this practice. In the future, if the DON or designee finds that a medication or medical item has not been dated when opened, or is expired and in use, she will discard the medication immediately and make sure that a new supply is ordered. Once that is done, she will supply additional training to the nurses and QMAs regarding the facility policy for dating medications and discarding those that are expired. Disciplinary action will be utilized for continued non-compliance. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</u></b></p>		

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	<p>Director of Nursing. For Resident #31 there were Artificial Tears, opened 9/26/12, still in the drawer, Delsym cough syrup with no opened date and the bottle was almost empty, Two bottles of Fluticasone Propionate nasal spray - one was dated as opened on 10/6/12 and the other one didn't have an opened date but had been used.</p> <p>Interview with the acting Director of Nursing on 11/30/12 at 9:30 a.m., she indicated their Corporate Nurse said things in the med cart are good in the med cart until the expiration date no matter when opened.</p> <p>A policy titled, "Specific Medication Administration Procedures" was received from the Director of Nursing on 11/29/12 at 3:40 p.m. This states, "...E. Check expiration date on package/container. When opening a multi-dose container, place the date on the container..."</p> <p>3.1-25(o)</p>		<p><u>recur?</u> A weekly audit of the medication and treatment cart and medication room will be done by the DON or designee to ensure that opened medication or biologicals have been dated when opened and that none are being used which have become expired. This will be done for 3 months. Any identified concerns will be addressed as indicated in question #2. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Director of Nursing/Designee will bring the results of the reviews to the monthly QA meeting for review and further recommendations. This reporting will continue for the next 3 months. The QA committee will determine the continued frequency of the review after the 3 month time period has elapsed and the facility has demonstrated 100% compliance. However, the review process will continue on an ongoing basis. <u>Date of Compliance:</u> 12/30/12</p>		

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F0514 SS=A	<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 complete and accurate documentation in clinical records in that 1 resident had an inaccurate fall risk assessment. (Resident #48)</p> <p>This affected 1 of 1 resident who fit the criteria for complete and accurate records.</p> <p>Findings include:</p> <p>Resident #48's record was reviewed on 11/29/12 at 8:35 a.m. The record indicated Resident #48 was admitted with diagnoses that included, but were not limited to, congestive heart failure, chronic obstructive pulmonary</p>	F0514	<p><b>F514</b> It is the policy of this facility to ensure there is complete and accurate documentation in the clinical records. <u>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> The fall risk assessment was completed for resident #48 on 11-29-12 to accurately reflect the score after her fall. The Director of Nursing will present re-education for licensed nurses on 12-18-12 reviewing the accuracy required for completion of each fall risk assessment. <u>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u> On December 10, 2012, the DON reviewed the fall</p>	12/30/2012			

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	<p>disease, high blood pressure, coronary artery disease with stents, history of heart attack, seizure disorder, and diabetes mellitus.</p> <p>Nurse's notes, dated 11/2/12 at 4:00 p.m., indicated: "Called to shower room - CNA stated Rd (resident) had been sitting on the shower chair &amp; stood up, &amp; grasped hand rail, then her knees buckled, CNA assisted Rd to the floor on Rt (right) side. Did not hit her head. B/P 140/86, P 76, R 18, Temp 98.7, O2 sats (oxygen saturation) 96%. Rd stated her Lt (left) ankle hurt, [no] changes in ROM or swelling..."</p> <p>A fall risk assessment was completed after this fall and was dated 11/2/12. The fall risk assessment indicated '0' in the column for "History of falls (past 3 months), and should have indicated '2.' The total score was 9 where if the total score is 10 or greater, the resident would be considered a high risk for potential falls.</p> <p>During an interview on 11/30/12 at 9:55 a.m., the DoN indicated the fall risk assessment, dated 11/2/12, had been completed after the fall and that staff are supposed to complete one after a fall.</p>		<p>risk assessments which had been done after a fall. There were no inaccuracies of the fall risk assessment noted and no other residents affected by this practice. In the future, if the DON /Designee find that a fall risk assessment has not been filled out correctly, she will make sure it is completed correctly at that time. Once that is done, the nurse who failed to accurately fill it out will receive additional training. Disciplinary action will be utilized for continued non-compliance. <b><u>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b> The Director of Nurses will take the fall risk assessments which are completed after a fall to the daily clinical meeting at least 5 days per week for review by the interdisciplinary team. Any concerns or issues identified as a result of those reviews will be addressed as indicated in question #2. <b><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The Director of Nurses/Designee will bring the results of the review to the monthly QA meeting for 3 months for team review and recommendations for process improvement. The QA committee will determine the continued frequency of the reviews after the</p>				

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	During an interview on 11/30/12 at 9:56 a.m., the Minimum Data Set Coordinator indicated the score for the history of falls "should have been a 1 or a 2."  3.1-50(a)(2)		3 month time period and when the facility has demonstrated 100% compliance. However, the review process as outlined in question #3 will continue on an ongoing basis. <u>Date of Compliance:</u> 12/30/12		