

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F0000	<p>This visit was for the Recertification and State Licensure Survey</p> <p>Survey Dates: May 14, 15, 16, 17, 18, 19, 20, and 21, 2012</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>Survey Team: Heather Tuttle, R.N.- T.C. 5/14-5/18 & 5/21/12 Lara Richards, R.N. 5/14-5/18 & 5/21/12 Kathleen Vargas, R.N.</p> <p>Census Bed Type: 173 SNF/NF 173 Total</p> <p>Census Payor Type: 29 Medicare 127 Medicaid 17 Other 173 Total</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 24, 2012 by Bev Faulkner, RN</p>	F0000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></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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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents who attended the Resident Council meetings were informed and given information on how to file a formal complaint with the State Department of Health. This had the potential to affect 173 residents who reside in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council President on 5/16/12 at 12:48 p.m., indicated she was not aware on how to file a formal complaint with the State Department of Health nor was she ever given information on how to formally file a complaint with the State Department of Health.</p> <p>Review of the Resident Council</p>	F0156	<p>All residents had the potential to be affected by the alleged deficient practice. Residents will be educated at resident council on 6/6/12. State department of health information is posted in the facility. The address and phone number for filing a complaint will be presented at resident council at least 4x per year starting on June 6, 2012. Resident Council minutes will be presented to the Executive Director monthly. The Executive Director or designee will interview the resident council president Quarterly utilizing the QIS Resident Council President Interview questions, to ensure the information was presented and understood. (Attachment #1 Resident Council Interview) The Executive Director will present the findings of the interview to the QAA committee for review and recommendations</p>	06/15/2012			

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	<p>meeting minutes from 9/11 indicated "Review of Resident Rights: The Resident has the right to exercise his or her legal rights, including filing a complaint with the State survey and certification agency concerning Resident abuse, neglect, and misappropriation of Resident property in the Facility."</p> <p>Interview with Activity Aide #1 on 5/16/12 at 1:27 p.m., indicated she does not recall ever informing the residents and giving them information on how to file a complaint with the State Department of Health. She further indicated when the old Activity Director was off and not in the facility it got very challenging. She indicated at the time, since the new Activity Director has been here (about six weeks) she knows they have not gone over that information with the Resident Council.</p> <p>Interview with the Activity Director on 5/16/12 at 2:00 p.m., indicated there was documentation from the 9/11 Resident Council meeting of their right to file a complaint, but there was no evidence the residents were given information on how to actually file the complaint along with addresses or telephone numbers.</p>						

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	3.1-4(j)(2)			

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F0172 SS=C	<p>483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at</p>			

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	<p>any time.</p> <p>Based on record review and interview, the facility failed to inform the Resident Council who the Ombudsman was or how to contact him/her. This had the potential to affect 173 residents who reside in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council President on 5/16/12 at 12:48 p.m., indicated she did not who the ombudsman was. She further indicated that was the first time she had ever heard that word before since she has lived in the facility. The President indicated she had resided in the facility for about 15 months and does not know if the Ombudsman was ever discussed in the meetings or not.</p> <p>Review of the Resident Council meeting minutes for the last six months indicated there was no documentation or indication the Ombudsman was ever discussed with the residents in the facility.</p> <p>Interview with Activity Aide #1 on 5/16/12 at 1:19 p.m., indicated the old Activity Director left in October 2011; however, she was off for several</p>	F0172	<p>All residents had the potential to be affected by the deficient practice. The Ombudsman information is now posted in the activity room. Residents will be educated at resident council on 6/6/12. Ombudsman information is posted in the activity room. The contact information has been printed in the facility newsletter for the month of June. The information on how to contact the Ombudsman will be presented at resident council at least 4x per year starting on June 6, 2012. Resident Council minutes will be presented to the Executive Director monthly. The Executive Director or designee will interview the resident council president Quarterly utilizing the QIS Resident Council President Interview questions, to ensure the information was presented and understood. (Attachment #1 Resident Council Interview) The Executive Director will present the findings of the interview to the QAA committee.</p>	06/15/2012	

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	<p>months before that, and a new one was hired in November 2011 toward the end of the month. The new Activity Director was only at the facility for three months then left. Further interview at the time, indicated during that time, Activity Aide #1 was running the Resident Council meetings and she indicated she did not discuss who the Ombudsman was during those meetings.</p> <p>Interview with the current Activity Director on 5/16/12 at 1:37 p.m., indicated she started orientation at the facility on March 22, 2012. She indicated since she has been here she has not gone over with the residents, who the Ombudsman was and how to contact him/her in the last two Resident Council meetings.</p> <p>3.1-8(b)(4)</p>				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure that a resident who displayed psychosocial adjustment difficulty received appropriate treatment and services related to identifying, monitoring and assessing behaviors and monitoring the use of antianxiety medications for 1 of 3 residents reviewed for psychoactive medications of the 12 residents who met the criteria for psychoactive medications. (Resident #45)</p> <p>Findings include:</p> <p>The record for Resident #45 was reviewed on 5/16/12 at 8:54 a.m. The resident was admitted to the facility on 4/20/12. The resident had diagnoses that included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension and anxiety.</p> <p>Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date of 4/27/12, indicated the resident could</p>	F0250	<p>A behavioral care plan was implemented for resident #45. All residents with orders for prn psychoactive medications have the potential to be affected by the alleged deficient practice. All residents with prn psychoactive medications will be reviewed for any administration in the past month. Staff is being interviewed to identify any residents having behaviors that may not be currently documented. All of these residents are being reviewed for behavioral care plans and appropriateness of the medication. All nursing staff are being re-educated regarding documentation of resident behaviors. Nurses will be re-educated on the Behavior Management Guideline and notifying social services when a prn psychoactive medication is administered. (Attachment #2 Behavior Management Guideline) Unit mangers will audit medication administration records and controlled substance logs weekly for prn psychoactive medication administration. DNS or designee will audit these residents for monitoring by social services, weekly x 4 weeks and then monthly utilizing the</p>	06/15/2012			

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	<p>understand and be understood. She had a BIMS (Brief Interview for Mental Status) score of 4 which indicated severe cognitive impairment. She had symptoms of feeling down, depressed or hopeless, feeling tired or having little energy, having a poor appetite or overeating, and feeling bad about herself or that she was a failure or have let herself or her family down. Her PHQ-9 (Resident Mood Interview) score was 6 (indicating mild depression). The MDS indicated the resident had not exhibited behaviors and no antianxiety medications were administered.</p> <p>There was an admission Physician Order dated 4/20/12. The order indicated Ativan (an antianxiety medication) 0.5 mg (milligrams) was to be administered by mouth prn (as needed) at bedtime for agitation.</p> <p>There was a Care Plan, dated 4/23/12, that indicated: Potential for drug related complications associated with use of psychotropic medications. The goal was: will be free of psychotropic related complications -assess for pain -monitor for side effects -monthly pharmacy review</p>		<p>Psychotropic Medication Audit. (Attachment #3 Psychotropic Medication Audit) DNS or designee will present to QAA findings of the audits. QAA committee to review for any trends or patterns and make recommendations.</p>		

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	<p>-provide meds as ordered</p> <p>The Social Service Progress Notes were reviewed. There was a Social Service Progress Note, dated 4/23/12 at 2:12 p.m., that indicated, "Resident entered facility 4/20/12 with order for Ativan 0.5 mg prn. Behavior log initiated."</p> <p>Review of the April 2012 Behavior Monthly Flow Sheet (Behavior Log) indicated the resident's behavior to monitor was "anxiety."</p> <p>A Social Service Progress Note, dated 4/27/12 at 3:14 p.m., indicated, "Resident is alert and oriented to self and family. Resident's BIMS score was 4 indicating she had severe cognitive impairment. Resident PHQ-9 score was 6 indicating mild depression. Per physician's order resident is to receive Ativan for diagnosis of anxiety. . ."</p> <p>Review of the form titled, "Controlled Drug Record," indicated Ativan was administered to the resident on the following days and times:</p> <p>4/27/12 at 11:00 p.m. 4/28/12 at 8 p.m. 4/29/12 at 8 p.m. 4/30/12 at 8 p.m.</p>				

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	<p>5/3/12 at 8 p.m. 5/6/12 at 7 p.m. 5/8/12 at 6 p.m. 5/9/12 at 7 p.m. 5/12/12 at 6 p.m. 5/13/12 at 5 p.m.</p> <p>The forms titled "Interventions Attempted Before Psychoactive Medications Given" were reviewed. There were only two forms available for review. One form was dated 5/12/12, and the other form was dated 5/13/12.</p> <p>Review of the form, dated 5/12/12, indicated the resident was agitated with loud conversation, refusing to eat, told staff to disappear and leave her alone. Non-pharmaceutical interventions were attempted. At 4:30 p.m., she was removed from the environment. At 4:45 p.m., a different staff member attempted to intervene. At 4:55 p.m., the resident was exercised and at 5:00 p.m., she was given a snack. Staff also tried television and a puzzle prior to the administration of 0.5 mg of Ativan.</p> <p>Review of the "Interventions Attempted Before Psychoactive Medications Given" form, dated 5/13/12, indicated the resident was yelling at staff. When medications</p>						

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	<p>were offered, staff were told to shove it up their bum, did not want to be around other people.</p> <p>Non-pharmaceutical interventions were attempted. She was removed from the environment, she was given an activity, staff tried to talk with her, different staff members attempted to intervene, she refused to ambulate or exercise, a snack was refused, television and a puzzle were offered and were not successful. Ativan was then given.</p> <p>There were no "Interventions Attempted Before Psychoactive Medications Given" forms completed before the administration of Ativan on 4/27/12 at 11:00 p.m., 4/28/12 at 8 p.m., 4/29/12 at 8 p.m., 4/30/12 at 8 p.m., 5/3/12 at 8 p.m., 5/6/12 at 7 p.m., 5/8/12 at 6 p.m. and 5/9/12 at 7 p.m.</p> <p>The April 2012 and May 2012 Medication Administration Records (MAR) were reviewed. There was documentation the resident received Ativan on 4/28/12, 5/12/12 and 5/13/12. There was no evidence that Ativan was administered any other days.</p> <p>The May 2012 Behavior Monthly Flow Sheet was reviewed. The only</p>				

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	<p>documented behaviors occurred on 5/6/12. There was 1 episode of "throwing things." There were no behaviors documented for 5/3/12, 5/8/12, 5/9/12, 5/12/12 and 5/13/12 on the behavior log.</p> <p>The April 2012 Behavior Monthly Flow Sheet indicated there was 1 episode of anxiety on April 28 and the interventions used were redirection and prn Ativan.</p> <p>Review of the nursing progress notes dated 4/27/12 through 5/13/12 indicated there was no evidence the resident had behaviors of anxiety or had non-pharmaceutical interventions used prior to the administration of Ativan on 4/27/12, 4/29/12, 4/30/12, 5/3/12, 5/8/12 and 5/9/12.</p> <p>Interview with the C-Wing Supervisor on 5/16/12 at 10:50 a.m., indicated prn interventions sheets were not completed each time the resident received Ativan. She indicated staff are to complete the form titled, "Interventions Attempted Before Psychoactive Medications Given," each time a prn antianxiety medication is given. She also indicated staff are to document the indication for the use of the antianxiety medication each time it is</p>			

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	<p>administered.</p> <p>The policy titled "Monitoring Medication Administration," dated 2007, was provided by the C-Wing Unit Supervisor on 5/16/12 at 2:00 p.m. She indicated the policy was current. The policy indicated, "Administration of medications is documented, including the frequency and reason for administration of as needed (PRN) medications."</p> <p>The policy titled "Medication Management" dated 2007, was provided by the C-Wing Unit supervisor on 5/16/12 at 2:10 p.m. She indicated the policy was current. The policy indicated, "Non-pharmacological interventions such as behavior modification or social services and their effects are documented as part of the care planning process, and are utilized by the prescriber in assessing the continued need for medication</p> <p>Interview with the Social Service Director on 5/16/12 at 10:45 a.m., indicated she monitored the use of prn psychoactive medications by reviewing the Medication Administration Records. Review of the May and April 2012 MARs indicated the resident received Ativan</p>			

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	<p>only 3 times yet, per review of the narcotic sheet the resident received the Ativan more often. She indicated she did not review the narcotic sheets routinely for Ativan administration. She indicated she was not aware the resident had received the Ativan 10 times since admission.</p> <p>The policy titled, "Behavior Management Committee Guidelines" that was undated, was provided by the Director of Nursing on 5/16/12 at 3:25 p.m. She indicated the policy was current. The policy indicated: The purpose of the Behavior Management Committee is to drive appropriate analysis of causal factors of behavior and the development of a resident specific behavior management plan. The interdisciplinary nature of this process is extremely important, as many individuals may have pertinent information that may assist the committee in developing interventions.</p> <p>Review of the current plan of care indicated there was no care plan for behaviors of anxiety, hitting at others and throwing things.</p> <p>Interview with the C-Wing Supervisor on 5/17/12 at 7:38 a.m., indicated she</p>				

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	<p>was informed the resident had thrown items while in the dining room. She indicated there was no care plan for the behavior.</p> <p>Interview with Social Service Worker #1, on 5/17/12 at 8:54 a.m., indicated there was no care plan for behaviors, she indicated that she was not aware of the resident's behavior of throwing food until yesterday, when she was informed of the behavior by the C-Wing Unit Supervisor. Social Service Worker #1 provided the resident computerized behavior log that was entered into the care tracker system by staff. There was a behavior coded on 5/4/12 that indicated the resident had a verbal symptom directed towards others and a verbal symptom not directed towards others. There was a behavior coded on 4/28/12 that indicated the resident had verbal and physical symptoms. Social Worker #1 indicated mood and behavior problems are to be entered into the caretracker by the Certified Nursing Assistants (CNAs) and the nursing staff as they occur.</p> <p>Interview with Social Worker #1 on 5/17/12 at 9:14 a.m., indicated the behavior management program was conducted during daily stand up meetings. She indicated that the</p>				

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	<p>nursing supervisors bring information related to behaviors and the use of prn psychoactive medications to the meetings. The behaviors and the interventions were discussed and care planning is initiated. Social Service Worker #1 indicated there was only one time that the resident's behaviors were discussed. The discussion occurred after the resident had verbal symptoms on 4/28/12, when she screamed at staff and hit staff. She indicated there had been an incident of throwing food on 5/6/12 which social services was unaware of. She indicated the information should have been brought to the meeting and discussed.</p> <p>Interview with the Social Service Director on 5/17/12 at 10:10 a.m., indicated the resident's behaviors, use of antianxiety medications and appropriate interventions for behavior management were not initiated for the resident. She indicated the social service department was not aware of the resident's psychosocial difficulties.</p> <p>3.1-34(a)</p>			

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F0253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls and door frames, peeling paint, marred and scratched dining room tables and chairs, discolored windowsills, cobwebs in the dining room windows, a broken floor tile and a discolored bathroom floor for 3 of 4 units. This had the potential to affect 158 of the 173 residents residing in the facility. (C-wing, B-Wing, Special Care Unit)</p> <p>Findings include:</p> <p>The following was observed during the Environmental Tour on 5/18/12 at 9:15 a.m. to 9:50 a.m.:</p> <p>On the C-Wing Unit</p> <p>a. In Room 202, there were black marred areas on the wall and on the inside of the bathroom door. 2 residents resided in the room.</p> <p>b. In Room 224, a 4 inch section of the ceiling over the resident's bed near the window, was peeling away.</p>	F0253	<p>All items found during the survey have been corrected in each unit. The Maintenance Department will do a room by room, space by space audit for any and all maintenance issues by June 15th. Any item found will be corrected as soon as possible. All items will be tracked until corrected on the monthly audit form until we can move it to the Building Search Engine. The Director of Maintenance will in - service the staff on the use of our Building search Engine reporting system. This system allows all staff members to report any maintenance issues. The maintenance staff will audit the building each month for any new items to be corrected. (Attachment #4 Maintenance Audit) The Department Head will report his findings during the monthly QA meeting. He will focus on any patterns and trends of repairs needed. The Maintenance Director will be responsible for the implementation of this Plan of Correction.</p>	06/15/2012	

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	<p>2 residents resided in the room.</p> <p>c. In Room 231, the inside of the bathroom door and the door frame of the bathroom had black mars and chipped paint on them. 1 resident resided in the room.</p> <p>d. In Room 233, there was a 4 inch area of peeling paint noted above the heat register. 2 residents resided in the room.</p> <p>e. The Rehab Dining Room on C-Wing had 3 of 4 window sills that were discolored a dark brown color.</p> <p>f. There was a broken corner tile in the left shower room on C- Wing. It needed to be replaced.</p> <p>63 residents resided on the C-Wing Unit.</p> <p>On the B-Wing Unit the following was observed:</p> <p>a. In Room 132, the wall was marred next to the bed near the window. 2 residents resided in the room.</p> <p>b. The B-Wing Beachwood Cafe had cobwebs noted in 3 of 4 window sills.</p> <p>c. 3 of the 4 window sills in the Beachwood Cafe were discolored and</p>			

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	<p>needed to be replaced.</p> <p>d. The B-Wing Sun Room had 1 of 2 window sills that were discolored brown and were in need of replacement.</p> <p>e. 4 of 4 dining room tables, in the B-Wing Sun room, had mars and scratches on them and were in need of repair and stain.</p> <p>62 resided on the B-Wing.</p> <p>On the Special Care Unit:</p> <p>a. In Room 324, there was an area of red discoloration on the floor approximately 5 inches in diameter underneath the toilet bowl in the bathroom. 2 residents resided in the room.</p> <p>b. 3 of 3 dining tables, had marred areas and scratches and were in need of repair in the main dining room of the Special Care Unit.</p> <p>33 residents resided in the special care unit.</p> <p>Interview with the Administrator on 5/18/12 at the time of the Environmental Tour indicated all the above areas were in need of repair or cleaning.</p>			

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	3.1-19(f)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Physician's Orders and Care Plans were followed related to mechanically altered diets and administration of prn (as needed) antianxiety medications for 1 of 3 residents reviewed for dental services of the 113 residents who met the criteria for dental services and 1 of 3 residents reviewed for psychoactive medications of the 12 residents who met the criteria for psychoactive medications. (Resident #45)</p> <p>Findings include:</p> <p>1. a. Resident #45 was observed on 5/15/12 at 2:26 p.m. She was in her room seated in a wheelchair. The resident was observed with some broken teeth on the bottom of her mouth.</p> <p>The resident was observed on 5/17/12 at 11:20 a.m., in the Rehab Dining Room on the C-Wing Unit, waiting for lunch to be served. At 11:44 a.m., the resident was served a</p>	F0282	<p>1. The facility was unable to correct the alleged deficient practice for resident #45. 2. All residents receiving mechanically altered diets have the potential to be affected. A full house audit of physician ordered diets was completed by comparing diet orders to meal tickets. All resident receiving prn psychoactive medications have the potential to be affected. All residents with prn psychoactive medication orders had their medication administration records reviewed for appropriate administration time. 3. Dietary staff re-educated on transcribing diet orders to the diet ticket system, Momentum. Nurses re-educated on inputting diet orders correctly into the order system PCC. Nurses will be re-educated on Medication Administration General Guidelines with focus on appropriate medication administration time. Competency will be evaluated with a medication administration test. (Attachment #5 Medication Administration General Guidelines and #6 Medication Competency Evaluation 4. RD will audit 3x per week x 4 weeks</p>	06/15/2012	

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	<p>whole braised pork chop with pan gravy, whipped sweet potato, oriental vegetables, and a slice of wheat bread. The braised pork chop was not ground or chopped.</p> <p>Observation of the steam table in the C-Wing dining room on 5/17/12 at 11:23 a.m., indicated there were ground pork chops. Interview with the Dietary Manager at that time, indicated the ground pork chops were for residents receiving a mechanical soft diet.</p> <p>The record for Resident #45 was reviewed on 5/16/12 at 8:54 a.m. The resident had diagnoses that included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension and anxiety.</p> <p>Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date of 4/27/12, indicated the resident had obvious or likely cavity or broken natural teeth, required extensive assistance of one staff member for eating, and received a therapeutic, mechanically altered diet. The MDS also indicated the resident had not received antianxiety medications.</p> <p>There was a Physician Order, dated</p>		<p>and then monthly x 6 months, utilizing the dietary tray ticket audit to ensure all diet changes are correctly reflected on the diet tickets. Dietary manager or designee will monitor 10% of residents with mechanically altered diets 1 meal per day 3x per week x 4 weeks and then monthly x 6 months rotating between all dining rooms and all meals. Unit managers will audit weekly to ensure diet orders are written correctly utilizing the Daily Start Up Audit. (on-going without stop date) (Attachment #7 Dietary Tray Ticket Audit & #8 Daily Start Up Audit) DCE or designee will audit Medication Administration, utilizing the Med Administration Competency, with 10% of nurses weekly x 4 weeks and then 10% monthly until 100% compliance has been reached for 3 consecutive months.</p> <p>(Attachment #9 Med Administration Competency) DNS and Dietary Service Manger will report results of the audits to the QAA committee for revision of action plan if any trends or significance are found.</p>		

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	<p>4/21/12, that indicated the resident was to receive a mechanical soft, no added salt diet.</p> <p>There was a Care Plan, dated 4/27/12, that indicated: Altered nutrition related to laboratory values as related to chronic kidney disease. Requires feeding assistance. Difficulty chewing/swallowing. Goals: will have no significant weight changes, will tolerate current diet, labs to remain within normal limits The interventions included -No salt packet, mechanical soft diet as ordered -monitor lab data as available -monitor meal consumption daily -dines in RDR (Rehab Dining Room) -supplements 5/6/12 -fortified foods breakfast and lunch 5/6/12</p> <p>Interview with the C- Wing Unit Supervisor on 5/17/12 at 1:20 p.m., indicated the resident had Physician's Orders to receive a mechanical soft diet. She also indicated the resident's Care Plan indicated she was to receive a mechanical soft diet.</p> <p>Interview with the Dietary Manager on 5/17/12 at 1:25 p.m., indicated the resident received a regular consistency diet at lunch on 5/17/12</p>						

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	<p>and had been receiving a regular consistency diet. She indicated the resident had not received the mechanically altered diet that was ordered by the Physician.</p> <p>b. Continued review of the record on 5/16/12 at 8:54 a.m., indicated an admission Physician Order dated 4/20/12. The order indicated Ativan (an antianxiety medication) 0.5 mg (milligrams) was to be administered by mouth prn (as needed) at bedtime for agitation.</p> <p>There was a Care Plan dated 4/23/12 that indicated Potential for drug related complications associated with use of psychotropic medications the goal was: will be free of psychotropic related complications -assess for pain -monitor for side effects -monthly pharmacy review -provide meds as ordered</p> <p>Review of the form titled, "Controlled Drug Record," indicated Ativan was administered to the resident on the following days and times:</p> <p>on 5/8/12 at 6 p.m. on 5/12/12 at 6 p.m. on 5/13/12 at 5 p.m.</p>			

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	<p>LPN #3 was interviewed on 5/16/12 at 9:51 a.m. She indicated the Physician's Order was for the Ativan to be administered to the resident as needed at the hour of sleep. She indicated the residents eat dinner at 5 p.m., so giving the Ativan at 5 p.m. or 6 p.m. would not be at the hour of sleep.</p> <p>Interview with the Director of Nursing on 5/16/12 at 2:46 p.m., indicated that HS (hour of sleep) for the facility was 7:00 P.M. She indicated the Ativan administered to the resident at 5:00 p.m. and at 6:00 p.m. was not administered as ordered by the physician.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure non pressure related skin conditions related to bruises were identified, assessed and monitored for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 who met the criteria for non pressure related skin conditions. (Residents #144 and #181)</p> <p>Findings include:</p> <p>1. On 5/14/2012 at 3:24 p.m., Resident #181 was observed in laying in bed. At that time, there were numerous bruises to his left arm that were red/purple in color.</p> <p>On 5/15/12 at 2:44 p.m., the resident was observed in bed, wearing a hospital gown. At that time, there were red/purple bruises observed to his left forearm. He indicated at the time that he did not know how they got there. He had thought he must</p>	F0309	<p>1. The physician and families of resident's #144 and #181 were notified of bruises on 5/16/12. Verification of investigation reports were completed and documentation completed in the progress notes. 2. All residents have the potential to be affected by the same deficient practice. All residents will have a skin assessment to identify any non pressure skin conditions not already identified. Residents identified with non pressure skin conditions will have the physician and families notified and verification of investigations completed along with documentation and monitoring in the progress notes. 3. CNA staff to be re-educated on observing daily for changes in skin integrity and reporting to the nurses any change in resident skin. (Attachment #10 Stop & Watch) 4. Unit managers will assess 10% of residents weekly x 4 weeks and then monthly to ensure all non pressure related skin conditions are identified, assessed and monitored utilizing the Non-pressure skin condition</p>	06/15/2012			

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	<p>have hit his arm on the assist rail located on the side of his bed.</p> <p>On 5/16/17 8:45 a.m., and 2:00 p.m., the resident was in his room laying in bed wearing a hospital gown. At those times there were purple/red bruises noted to his left forearm.</p> <p>The record for Resident #181 was reviewed on 5/16/12 at 9:00 a.m. The resident was admitted from the hospital on 1/14/12. The resident's diagnoses included, but were not limited to, chronic ischemic heart disease, anxiety, dementia with behavioral disturbances, chronic airway obstruction, high blood pressure, diabetes, congestive heart failure, and blindness to both of his eyes.</p> <p>Review of initial Minimum Data Set (MDS) assessment, dated 1/20/12, indicated the resident was able to be understood and understands, his vision was moderately impaired, and he was alert and oriented to person, place, and time, and able to make good decisions. He needed supervision to limited assist with his activities of daily living including transfers, dressing and grooming.</p> <p>Review of the weekly skin checks</p>		<p>Audit. (Attachment #11 Non-Pressure Skin Condition Audit) DNS or designee will present to QAA findings of the audits. QAA committee to review for any trends or patterns and make recommendations.</p>				

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	<p>(shower sheets), dated 5/5, indicated the resident refused his shower. There were no skin issues identified on the sheet. Review of the shower sheet, dated 5/8, indicated there were no new skin issues and the sheet was signed by the CNA who bathed him, but lacked the nurse's signature. Review of the 5/10/12 shower sheet indicated there were no skin issues and it was also signed by the CNA who showered him, but again lacked the nurse's signature. Review of the 5/16/12 shower sheet indicated there were no skin issues including bruises and the sheet was signed by the CNA who showered him as well as the nurse who assessed his skin.</p> <p>Review of Nurses Notes, dated 5/2-5/15/12, indicated there was no documentation or assessment regarding any bruises to the resident's left arm.</p> <p>Interview with LPN #4 on 5/16/12 at 2:31 p.m., indicated she was unaware the resident had any bruises to his left arm. She further indicated that she was the nurse who completed the shower sheet on 5/16/12. The LPN indicated the CNA working with the resident did not inform her of any bruising to his arms nor did anyone tell her all week about the bruising.</p>				

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	<p>She indicated it was the facility's policy to complete an incident report, assess and measure the bruises when found. She also indicated they were to be placed on the wound evaluation flow sheet and monitored weekly until gone.</p> <p>Interview with the B-Wing Unit Manager on 5/16/12 at 2:18 p.m., indicated there were no events regarding bruising for Resident #181 in the computer. She further indicated there were no new skin conditions identified for the resident in the chart in Nursing Progress Notes. The Unit Manager indicated the nurses were expected to measure the bruises, fill out an incident report and start an investigation. They were also expected to document the location and size and put them on the wound evaluation sheet.</p> <p>On 5/16/12 at 2:45 p.m., the resident's bruises were measured by LPN #4 and placed on the wound evaluation sheets.</p> <p>Interview with the Director of Nursing on 5/16/12 at 3:00 p.m., indicated it was her expectations for Nursing staff to identify, assess, measure and document all newly acquired bruises and put them on the wound</p>						

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	<p>evaluation sheets. The bruises were to be monitored for 72 hours in Nurses Notes and then weekly on the wound evaluation sheets until healed.</p> <p>2. Resident #144 was observed on 5/15/12 at 9:25 a.m. A 1 inch bruise was noted on the resident's right hand.</p> <p>On 5/16/12 at 1:40 p.m., the resident was observed. He had a bruise on the top of his left hand that was about 1 inch in size. There were several smaller bruises also noted on his left hand. On the resident's right hand there was a bruise that was 2 inches in size.</p> <p>Interview with LPN #1 on 5/16/12 at 1:45 p.m., observed and acknowledged the resident did have bruises on both his left and right hands. She indicated she was not aware of the bruises and had not been notified that the resident had bruises.</p> <p>Continued interview with LPN #1 on 5/16/12 at 1:45 p.m., indicated that when a bruise was first noted, an incident report was to be completed, the family and the physician were to be notified. She indicated the bruises were to be assessed and measured</p>						

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	<p>when they were first noted and then weekly until they were resolved.</p> <p>Resident #144's chart was reviewed on 5/16/12 at 11:00 a.m. The resident had diagnoses that included, but were not limited to, stroke, hypertension and depression.</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date of 3/26/12, indicated the resident was understood and understands. He required total assist of 2 persons with bed mobility and transfers.</p> <p>Review of the current Physician's Order Sheet, dated 4/2/12, indicated the resident was receiving aspirin 81 mg (milligrams) daily for long-term use of anticoagulants (blood thinning medications).</p> <p>Review of the current Care Plan indicated there was no Care Plan for bruising.</p> <p>Review of the nursing progress notes, dated 5/1/12 through 5/16/12, indicated there was no evidence that the bruises had been noted and assessed.</p>			

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	<p>The change of condition note, dated 5/16/12 at 2:00 p.m., was reviewed. It was completed by LPN #1. It indicated: "bruising to top of left hand 0.5 cm (centimeters) x 0.5 cm red, 0.3 x 0.2 cm red, 0.5 x 0.2 cm red, top outer left hand 1.5 x 0.7 cm purple bruise, top left hand under 4th finger 0.3 x 0.2 cm red bruise, right middle wrist 1 cm x 0.5 cm purple, right hand 4 cm x 2 cm purple brown bruise near thumb, right wrist .4 cm x .3 cm red bruise, three .1 x .1 cm red bruises, right inner wrist 1.5 x 0.5 cm purple bruise, three 0.1 cm x .1 cm red bruises, right upper arm 2.5 cm x 1.5 cm red bruise."</p> <p>Interview with the DoN on 5/20/12 at 8:51 a.m., indicated the CNA's were to report any changes in status to the nurse. She indicated the resident's bruises should have been identified by staff and assessed before 5/16/12.</p> <p>3.1-37(a)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure non-pharmaceutical interventions were attempted prior to the use of an antianxiety medication and the facility also failed to ensure there were adequate indications for the use of an as needed (prn) antianxiety medication for 1 of 3 residents reviewed for psychoactive medications of the 12 residents who met the criteria for psychoactive medications. (Resident #45)</p>	F0329	<p>1. We were unable to correct the alleged deficient practice for resident #45. 2. Residents with orders for prn psychoactive medications have the potential to be affected by the alleged deficient practice. All residents receiving prn psychoactive medications were reviewed by the interdisciplinary team for indication and continued appropriateness of the medication. MD will be contacted for any required changes with current orders. <input type="checkbox"/>3. Re-educate staff on attempting</p>	06/15/2012	

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	<p>Findings include:</p> <p>The record for Resident #45 was reviewed on 5/16/12 at 8:54 a.m. The resident had diagnoses that included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension and anxiety.</p> <p>Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date of 4/27/12, indicated the resident could understand and be understood. She had a BIMS (Brief Interview for Mental Status) score of 4 which indicated severe cognitive impairment. She had symptoms of feeling down, depressed or hopeless, feeling tired or having little energy, having a poor appetite or overeating, and feeling bad about herself or that she was a failure or have let herself or her family down. Her PHQ-9 (Resident Mood Interview) score was 6 (indicating mild depression). The MDS indicated the resident had not exhibited behaviors and no antianxiety medications were administered.</p> <p>The resident was admitted to the facility on 4/20/12. There was an admission Physician Order dated</p>		<p>non-pharmaceutical interventions prior to administration of prn psychoactive medications. Re-educate Nurses on Behavior Management Guideline and required documentation of attempted non-pharmaceutical interventions. Re-educate nurses on documentation requirements when administering prn psychoactive medication. (Attachment #2 Behavior Management Guideline) 4. Residents with orders for prn psychoactive medications will have their controlled substance logs and medication administration records reviewed for medication administration. Unit Managers will Audit residents with prn psychoactive medications for documentation of the behavior as well as non-pharmaceutical interventions prior to administration. Unit Manager will complete audit weekly x 4 weeks and then monthly utilizing the psychotropic medication audit. (Attachment #3 Psychotropic Medication Audit) DNS or designee to report to QA any medications administered without appropriate indication and/or non-pharmaceutical interventions. QA committee to review and make recommendations for continued auditing or revision of action plan. The Director of Nursing is responsible for monitoring this Plan if Correction</p>		

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	<p>4/20/12. The order indicated Ativan (an antianxiety medication) 0.5 mg (milligrams) was to be administered by mouth prn (as needed) at bedtime for agitation.</p> <p>There was a Care Plan, dated 4/23/12, that indicated: Potential for drug related complications associated with use of psychotropic medications. The goal was: will be free of psychotropic related complications -assess for pain -monitor for side effects -monthly pharmacy review -provide meds as ordered</p> <p>The Social Service Progress Notes were reviewed. There was a Social Service Progress Note, dated 4/23/12 at 2:12 p.m., that indicated, "Resident entered facility 4/20/12 with order for Ativan 0.5 mg prn. Behavior log initiated."</p> <p>Review of the April 2012 Behavior Monthly Flow Sheet (Behavior Log) indicated the resident's behavior to monitor was anxiety.</p> <p>A Social Service Progress Note, dated 4/27/12 at 3:14 p.m., indicated, "Resident is alert and oriented to self and family. Resident's BIMS score</p>			

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	<p>was 4 indicating she had severe cognitive impairment. Resident PHQ-9 score was 6 indicating mild depression. Per physician's order resident is to receive Ativan for diagnosis of anxiety..."</p> <p>Review of the form titled, "Controlled Drug Record," indicated Ativan was administered to the resident on the following days and times:</p> <p>4/27/12 at 11:00 p.m. 4/28/12 at 8 p.m. 4/29/12 at 8 p.m. 4/30/12 at 8 p.m. 5/3/12 at 8 p.m. 5/6/12 at 7 p.m. 5/8/12 at 6 p.m. 5/9/12 at 7 p.m. 5/12/12 at 6 p.m. 5/13/12 at 5 p.m.</p> <p>The forms titled "Interventions Attempted Before Psychoactive Medications Given" were reviewed. There were only two forms available for review. One form was dated 5/12/12, and the other form was dated 5/13/12.</p> <p>Review of the form, dated 5/12/12, indicated the resident was agitated with loud conversation, refusing to eat, told staff to disappear and leave</p>			

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	<p>her alone. Non-pharmaceutical interventions were attempted. At 4:30 p.m., she was removed from the environment. At 4:45 p.m., a different staff member attempted to intervene. At 4:55 p.m., the resident was exercised and at 5:00 p.m., she was given a snack. Staff also tried television and a puzzle prior to the administration of 0.5 mg of Ativan.</p> <p>Review of the "Interventions Attempted Before Psychoactive Medications Given" form, dated 5/13/12, indicated the resident was yelling at staff. When medications were offered, staff were told to shove it up their bum, did not want to be around other people.</p> <p>Non-pharmaceutical interventions were attempted. She was removed from the environment, she was given an activity, staff tried to talk with her, different staff members attempted to intervene, she refused to ambulate or exercise, a snack was refused, television and a puzzle were offered and were not successful. Ativan was then given.</p> <p>There were no "Interventions Attempted Before Psychoactive Medications Given" forms completed before the administration of Ativan on 4/27/12 at 11:00 p.m., 4/28/12 at 8</p>				

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	<p>p.m., 4/29/12 at 8 p.m., 4/30/12 at 8 p.m., 5/3/12 at 8 p.m., 5/6/12 at 7 p.m., 5/8/12 at 6 p.m. and 5/9/12 at 7 p.m.</p> <p>The May 2012 Behavior Monthly Flow Sheet was reviewed. The only documented behaviors occurred on 5/6/12. There was 1 episode of "throwing things." There were no behaviors documented for 5/3/12, 5/8/12, 5/9/12, 5/12/12 and 5/13/12 on the behavior log.</p> <p>The April 2012 Behavior Monthly Flow Sheet indicated there was 1 episode of anxiety on April 28 and the interventions used were redirection and prn Ativan.</p> <p>Review of the nursing progress notes, dated 4/27/12 through 5/13/12, indicated there was no evidence that the resident had behaviors of anxiety or had non-pharmaceutical interventions used prior to the administration of Ativan on 4/27/12, 4/29/12, 4/30/12, 5/3/12, 5/8/12 and 5/9/12.</p> <p>The April 2012 and May 2012 Medication Administration Records (MAR) were reviewed. There was documentation that the resident received Ativan on 4/28/12, 5/12/12</p>						

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	<p>and 5/13/12. There was no evidence that Ativan was administered any other days.</p> <p>Interview with the C-Wing Supervisor on 5/16/12 at 10:50 a.m., indicated prn interventions sheets were not completed each time the resident received Ativan. She indicated staff are to complete the form titled, "Interventions Attempted Before Psychoactive Medications Given," each time a prn antianxiety medication is given. She also indicated staff were to document the indication for the use of the antianxiety medication each time it was administered.</p> <p>The policy titled "Monitoring Medication Administration," dated 2007, was provided by the C-Wing Unit Supervisor on 5/16/12 at 2:00 p.m. She indicated the policy was current. The policy indicated, "Administration of medications is documented, including the frequency and reason for administration of as needed (PRN) medications."</p> <p>The policy titled "Medication Management," dated 2007, was provided by the C-Wing Unit Supervisor on 5/16/12 at 2:10 p.m. She indicated the policy was current.</p>						

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	<p>The policy indicated, "Non-pharmacological interventions such as behavior modification or social services and their effects are documented as part of the care planning process, and are utilized by the prescriber in assessing the continued need for medication." 3.1-48(a)(4)</p>				

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F0367 SS=D	<p>483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received a therapeutic diet of mechanically altered food solids, as ordered by the physician for 1 of 3 residents reviewed for dental services of the 113 residents who met the criteria for dental services. (Resident #45)</p> <p>Findings include:</p> <p>Resident #45 was observed on 5/15/12 at 2:26 p.m. She was in her room seated in a wheelchair. The resident was observed with some broken teeth on the bottom of her mouth.</p> <p>The resident was observed on 5/17/12 at 11:20 a.m., in the Rehab Dining Room on the C-Wing Unit, waiting for lunch to be served. At 11:44 a.m., the resident was served a whole braised pork chop with pan gravy, whipped sweet potato, oriental vegetables, and a slice of wheat bread. The braised pork chop was not ground or chopped.</p>	F0367	<p>The facility was unable to correct the alleged deficient practice for resident #45. 2. All residents receiving mechanically altered diets have the potential to be affected. A full house audit of physician ordered diets was completed by comparing diet orders to meal tickets. 3. Dietary staff re-educated on transcribing diet orders to the diet ticket system, Momentum. Nurses re-educated in inputting diet orders correctly into the order system PCC. 4. RD will audit 3x per week x 4 weeks and then monthly x 6 months, utilizing the dietary tray ticket audit to ensure all diet changes are correctly reflected on the diet tickets. Dietary manager or designee will monitor 10% of residents with mechanically altered diets 1 meal per day 3x per week x 4 weeks and then monthly x 6 months rotating between all dining rooms and all meals. Unit managers will audit diet orders weekly to ensure diet orders are written correctly utilizing the Daily Start Up Audit. (on-going without stop date) (Attachment #7 Dietary Ticket Audit) DNS and Dietary Service Manger will report results of the audits to the QAA committee for revision of action</p>	06/15/2012			

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	<p>Observation of the steam table in the C-Wing dining room on 5/17/12 at 11:23 a.m., indicated there were ground pork chops. Interview with the Dietary Manager at that time, indicated the ground pork chops were for residents on a mechanical soft diet.</p> <p>The record for Resident #45 was reviewed on 5/16/12 at 8:54 a.m. The resident had diagnoses that included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension and anxiety.</p> <p>Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date of 4/27/12, indicated the resident had obvious or likely cavity or broken natural teeth, required extensive assistance of one staff member for eating, and received a therapeutic, mechanically altered diet.</p> <p>There was a Physician order, dated 4/21/12, that indicated the resident was to receive a mechanical soft, no added salt diet.</p> <p>There was a care plan, dated 4/27/12, that indicated: Altered nutrition related to laboratory values as related to chronic kidney</p>		plan if any trends or significance are found.				

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	<p>disease. Requires feeding assistance. Difficulty chewing/swallowing. Goals: will have no significant weight changes, will tolerate current diet, labs to remain within normal limits</p> <p>The interventions included</p> <ul style="list-style-type: none"> -No salt packet, mechanical soft diet as ordered -monitor lab data as available -monitor meal consumption daily -dines in RDR (Rehab Dining Room) -supplements 5/6/12 -fortified foods breakfast and lunch 5/6/12 <p>Interview with the resident's daughter on 5/14/12 at 1:18 p.m., indicated the resident had dental problems with chewing difficulty, but she was being seen by a Speech Therapist.</p> <p>Continued review of the record for Resident #45 on 5/16/12 at 8:54 a.m., indicated there was a Speech Therapy Plan of Care that was completed on 4/23/12. The Plan of Care written by Speech Therapist #1, indicated the reason for the referral was: Patient is a (age of resident) year old female who presents with a decline in ability to safely take regular solids due to decreased OM (oral motor) /ROM (range of motion) /strength and decline in memory function, attention to tasks, and ability</p>						

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	<p>to follow directions following hospitalization for chronic kidney disease for about 3 weeks. Patient was admitted to this facility for short term rehabilitation. Skilled Speech Therapy required to evaluate patient and determine underlying impairments which can be restored and provide skilled treatment to get patient as close as possible to prior level of function. Speech Therapy to treat 5 times/weekly for 4 weeks to improve bolus formation/control, oral motor ROM/strength endurance, and mastication for safe oral intake and more precise movements, and to improve memory function, attention to tasks and ability to follow directions for improved ability to functions safely in environment.</p> <p>Precautions: altered diet of mechanical soft solids, fatigues easily, poor appetite.</p> <p>The Speech Therapy progress note, dated 5/11/12, indicated, "The patient is able to masticate food adequately to safely consume a mechanical soft diet taken in RDR with assistance from staff to initiate due to poor appetite."</p> <p>On 5/18/12 at 10:31 a.m., Speech Therapist #1 was interviewed. She indicated that she had been seeing</p>			

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	<p>the resident for cognition and dysphagia (difficulty swallowing). She indicated the resident had problems with endurance and fatigued easily. Since admission, she had been on a mechanical soft diet due to overall weakness. She indicated that it was her recommendation the resident was to remain on a mechanical soft diet. She indicated the resident had a urinary tract infection, which set her back physically. She indicated she performed oral motor exercises with the resident. She indicated the resident had been having some trials with regular consistencies of food, but she never made a recommendation to have her diet changed to regular diet.</p> <p>Interview with the Registered Dietitian on 5/18/12 at 8:51 a.m., indicated she had made no recommendations for the diet to be changed to a regular consistency.</p> <p>Interview with the C- wing Unit Supervisor on 5/17/12 at 1:20 p.m., indicated the resident had Physician's Orders to receive a mechanical soft diet.</p> <p>Interview with the Dietary Manager on 5/17/12 at 1:25 p.m., indicated the resident received a regular consistency diet at lunch on 5/17/12</p>			

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	<p>and had been receiving a regular consistency diet. She indicated the resident had not received the mechanically altered diet that was ordered by the Physician and recommended by the Speech Therapist for safe consumption.</p> <p>3.1-21(b)</p>			

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F0441	We were unable to correct the alleged deficient practice for	06/15/2012	

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	<p>ensure nursing staff followed the facility's infection control policies and procedures for the administration of eye drops to 1 of 1 residents observed during medication administration. (Resident #104)</p> <p>Findings include:</p> <p>On 5/16/12 at 3:34 p.m., the medication administration pass was observed with LPN #2. LPN #2 set up oral medications for Resident #104. She also obtained a bottle of Artificial Tears (eye drops) for the resident. She put the oral medications in pudding and gave them to the resident. She then administered the eye drops to the resident. She placed 1 drop in each eye. She did not apply gloves prior to giving the eye drops.</p> <p>The policy titled,"Eye Drops," dated 2007, was provided by the Director of Nursing on 5/17/12 at 9:00 a.m. She indicated the policy was current. The policy indicated: "equipment needed to administer ophthalmic solution into eye in a safe and accurate manner, -eye drops -sterile gauze pad or tissues -gloves, per facility policy -antimicrobial agent for hand hygiene."</p>		<p>resident #104. All residents receiving eye drops have the potential to be affected by the deficient practice. During medication observations no other residents were noted to be affected by the deficient practice.</p> <p>Nurses will be re-educated on procedure for administration of eye drops and utilization of gloves. Nurses will complete competency on administration of eye drops and utilization of gloves. Nurses who do not pass competency will be re-educated and re-tested prior to medication administration. (Attachment #12 Medication Administration Eye Drops Policy) Based on Medication Administration Competency guideline, all newly hired nurses will have to demonstrate correct administration of eye drops prior to passing medications independently. Nurses will be evaluated at least annually using the Med Pass Observation checklist. (Attachment #13 Medication Administration Competency guideline, Attachment #14 Medication Pass Observation Checklist) DNS or designee will submit results to the QAA committee and evaluate any trends or patterns.</p>		

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	<p>Interview with the Director of Nursing on 5/17/12 at 9:45 a.m., indicated it was the facility's practice to use gloves when administering eye drops. She indicated the nurse should have used gloves when instilling the eye drops to the resident's eyes.</p> <p>3.1-18(b)(2)</p>			

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F0520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of the use of antianxiety medications related to the administration of as needed antianxiety medication and behavior monitoring through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator on 5/18/12 at 2:39 p.m., indicated the</p>	F0520	All residents receiving prn psych medications had the potential to be affected by the alleged deficient practice. QAA plan written for use of non-compliance with anti-anxiety medications. Re-educate all department managers on the purpose of QA. Re-educate on informing the QAA committee of identification of concerns and modification and correction of facility systems when needed. QAA committee will meet monthly and review identified concerns and any	06/15/2012	

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	<p>facility's Quality Assurance Committee meets every month and consists of himself, the Director of Nursing, and department heads as well as the Medical Director. The Administrator indicated at the time, as he reviewed the minutes from the last three meetings, the concern of monitoring as needed antianxiety medications and ensuring the nurses were documenting in the Care Tracker the use of and the administration of as well as the resident's behaviors had not been addressed or identified as being a problem in Quality Assurance. He indicated there had been no action plan or system put into place to identify the problem of the use of as needed antianxiety medications and ensuring the resident's behaviors were monitored and communicated to Social Services.</p> <p>He further indicated at the time, the current practice or standard was for nursing staff to document in the care tracker their concerns with resident behaviors or bring it to Social Services attention by filling out a grievance form or through the morning meetings.</p> <p>Interview with the Director of Nursing on 5/21/12 at 9:44 a.m., indicated</p>		<p>modification or corrections along with monitoring of these modifications. ED will ensure that QAA committee is meeting monthly. ED will ensure the QAA team is developing plans of action to correct deficiencies and the team is monitoring the effects of the corrections.</p>		

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	<p>nursing staff were to ensure documentation was completed in the Care Tracker regarding the administration of as needed antianxiety medications as well as the behavior monitoring. She further indicated nursing staff were to document on the 24 hour report as well regarding any new behaviors or medication administration. The Director of Nursing indicated this problem with the administration of as needed antianxiety medication and behavior monitoring had not been addressed in the Quality Assurance meetings.</p> <p>The policy titled, "Behavior Management Committee Guidelines" that was undated, was provided by the Director of Nursing on 5/16/12 at 3:25 p.m. She indicated the policy was current. The policy indicated: The purpose of the Behavior Management Committee is to drive appropriate analysis of causal factors of behavior and the development of a resident specific behavior management plan. The interdisciplinary nature of this process is extremely important, as many individuals may have pertinent information that may assist the committee in developing interventions.</p>			
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	<p>The policy titled "Monitoring Medication Administration," dated 2007, was provided by the C-Wing Unit Supervisor on 5/16/12 at 2:00 p.m. She indicated the policy was current. The policy indicated, "Administration of medications is documented, including the frequency and reason for administration of as needed (PRN) medications."</p> <p>The policy titled "Medication Management" dated 2007, was provided by the C-Wing Unit Supervisor on 5/16/12 at 2:10 p.m. She indicated the policy was current. The policy indicated, "Non-pharmacological interventions such as behavior modification or social services and their effects are documented as part of the care planning process, and are utilized by the prescriber in assessing the continued need for medication.</p> <p>Interview with the Social Service Director on 5/16/12 at 10:45 a.m., indicated she monitored the use of prn psychoactive medications by reviewing the Medication Administration Records. She indicated she did not review the narcotic sheets routinely for psychotropic medication administration.</p>						

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	<p>Interview with Social Worker #1 on 5/17/12 at 9:14 a.m., indicated the behavior management program was conducted during daily stand up meetings. She indicated that the nursing supervisors bring information related to behaviors and the use of prn psychoactive medications to the meetings. The behaviors and the interventions were discussed and care planning was initiated.</p> <p>Interview with the Social Service Director on 5/17/12 at 10:10 a.m., indicated the resident's behaviors, use of antianxiety medications and appropriate interventions for behavior management were not initiated for residents when the information was not put into the care tracker by nursing staff, therefore Social Services do not become aware of residents with psychosocial difficulties and their behaviors.</p> <p>3.1-52(b)(2)</p>			