

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the the Investigation of Complaints IN00164413 and IN00163649.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00166854.</p> <p>Complaint IN00163649- Substantiated. Federal/State deficiency related to the allegation is cited at F-441.</p> <p>Complaint IN00164413- Substantiated. Federal/State deficiencies related to the allegations are cited at F-226, F-250, F-282, & F-514.</p> <p>Survey dates: February 9, 10, 11, 12, 13, 17 and 18th, of 2015</p> <p>Facility number: 000082 Provider number: 155165 AIM number: 100289640</p> <p>Survey team: Josh Emily, RN, TC Trudy Lytle, RN Gloria Reisert, LSW</p> <p>Census bed type:</p>	F 000	Requesting Paper Compliance	
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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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F 226 SS=E Bldg. 00	<p>SNF/NF: 115 Total: 115</p> <p>Census payor type: Medicare: 19 Medicaid: 70 Private: 12 Other: 14 Total: 115</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 26, 2015, by Janelyn Kulik, RN.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their Policy and Procedure on "Abuse" related to no follow-up assessments and monitoring of the residents' well-being after the incidents were completed in a timely manner by Supervisory and direct-care staff. This deficient practice</p>	F 226	<p>F226</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents B and C no longer resides at the facility. Residents H, G, I, and J affected by the deficient practice have been identified by the interdisciplinary team and have had their follow up</p>	03/12/2015

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	<p>affected 5 of 8 residents reviewed for Abuse. (Residents #C, #H, #G, # I, and #J.)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #C on 2/12/2015 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: depressive disorder, dementia, and insomnia.</p> <p>On 2/12/15 at 2:45 p.m., the Director of Nursing (DON) presented a copy of an "Incident Report Form" to State regarding an incident in which Resident #B hit Resident #C with a wooden object. Resident #C had bruising and swelling to the right hand, laceration to the top of the head, laceration behind right ear, and hematoma above the right eye. The "Incident Report Form" indicated the immediate action taken was an assessment was completed and Resident #C was sent to the emergency room for evaluation and treatment. Resident #B had increased agitation and was one on one until the police arrived. The "Incident Report Form" indicated the preventive measures taken were Resident #B was removed from the facility and was not readmitted. Also the Memory Care Facilitator or designee will follow</p>		<p>for emotional and psychosocial distress. All careplans and cna assignment sheets have been updated.</p> <p>1.How will you identify other residentshaving the potential to be affected by the same deficient practice? All residents have the potential tobe affected by the alleged deficient practice. 100% audit completed by SS/DNS forresident to resident altercations will be completed by 3/12/2015 to ensure allfollow up documentation completed per protocol.</p> <p>1.What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not occur? SS and MCF re educated on resident to resident altercations protocol on 3/6/15 by CEC and DNS. DNS/Designee will review SS notes during clinical meeting to ensure appropriate follow up is provided and follow upon. SS and MCF will be informed of resident to resident altercations when they occur to ensure proper follow up documentation has beencompleted. SS and MCF will review all behavior events during clinical meeting.</p> <p>1.How the corrective actions will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place.</p>				

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	<p>up with Resident # C for seventy two hours for any signs or symptoms of distress noted.</p> <p>Review of the progress notes for Resident #C on 2/12/2015 at 10:10 a.m., indicated when the resident returned from hospital on 01/23/2015 was visited by the Memory Care Facilitator and was not seen again by the Memory Care Facilitator until 01/26/2015.</p> <p>2. Review of the clinical record for Resident #H on 2/12/15 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia and Alzheimer's.</p> <p>On 2/11/15 at 1:42 p.m., the Director of Nursing (DON) presented a copy of an "Incident Report Form" to State regarding an incident reported to her that day by Resident #(E) between Resident #G and #H which had occurred a few weeks ago. He reported that Resident #H rolled her w/c over to Resident #G and Resident #G yelled at her.</p> <p>Upon investigation, it was determined that no yelling occurred - Resident #G told Resident #H to move her w/c back and Resident #H just made a comment back to her but did not yell at her.</p>		<p>To ensure compliance, theSS/MCF/Designee is responsible for the completion of the resident to residentialtercation CQI tool daily times 2 weeks, then weekly times 12 weeks, thenmonthly times 6 months to ensure preventative measures are in place. Ifthreshold of 95% is not achieved an action plan will be developed. Findingswill be reported in continuous quality improvement every month for a minimum of6 months.</p>				

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	<p>On 2/11/15 at 2:05 p.m., the DON presented a copy of another reportable to State in which all 3 residents were involved on the same issue again this morning. Resident #E reported Resident #G yelled and cussed at Resident #H when Resident #H rolled her w/c over to Resident #G and got too close.</p> <p>One of the Preventative measures listed for Residents #C, #H, #G, # I, and #J, on the Incident Reports was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being.</p> <p>Review of the Social Service and Interdisciplinary Notes for Residents #H, #G, # I, and #J, documentation was lacking of the resident having been monitored for emotional distress until 2/13/15 - 2 days after the incident occurred.</p> <p>3. Review of the clinical record for Resident #G on 2/12/15 at 10:30 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behaviors, mild intellectual disabilities, depression and intermittent explosive disorder.</p> <p>On 2/11/15 at 1:42 p.m., the DON presented a copy of an "Incident Report</p>			

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	<p>Form" to State regarding an incident reported to her by Resident #E that a few weeks ago Resident #H rolled her w/c over to Resident #G and Resident #G yelled at her.</p> <p>On 2/11/15 at 2:05 p.m., a staff interview with both the DON and Assistant DON indicated, "Resident #E does not like Resident #G so he's always trying to start something with her. She is loud due to being hard of hearing and she just sometimes talks out loud even if no one is there - talks to herself and she does get bossy at times and will say things like it is. He does not like that."</p> <p>On 2/11/15 at 2:05 p.m., the DON presented another "Incident Report Form" to State in which all 3 residents were involved in the same issue again. Resident #E reported Resident #G yelled and cussed at Resident #H when Resident #H rolled her w/c over to #G and got too close.</p> <p>One of the Preventative measures listed for Residents #C, #H, #G, # I, and #J, on the Incident report was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being.</p> <p>Review of the Social Service and</p>			

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	<p>Interdisciplinary Notes Residents #H, #G, # I, and #J failed to locate documentation of the resident being monitored for emotional distress until 2/13/15 - 2 days after the incident occurred.</p> <p>On 2/12/15 at 2:30 p.m., Social Worker #1 indicated that after an altercation or incident between 2 residents, she monitored residents at least weekly unless they needed more.</p> <p>4. Review of the clinical record for Resident #I on 2/13/15 at 10:22 am, indicated the resident had diagnoses which included, but were not limited to: paranoid state and dementia with behavioral disturbance.</p> <p>A 2/9/15 note by Social Services indicated "IDT (Interdisciplinary Team) review related to Resident #I was aggressive toward another resident who wandered in to his room when he tried to redirect her he pushed her and she fell (sic), no injuries sustained related to fall. resident denied being in pain or having unmet needs, he just finished a course of ATB (antibiotic) related to cold, UA (Urinalysis) and labs ordered per MD (physician), to rule out infection as a route (sic) cause. The route (sic) cause of his bc (behaviors) appears to be the wandering of the other resident in his</p>			

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	<p>room. Will ensure his door is shut to help prevent other resident from wandering in to his room."</p> <p>On 2/12/15 at 3:53 p.m., the DON presented the 5 day f/u report that was sent to the State on a 2/7/15 incident between this resident and another resident due to the resident wandering into his room and going through his belongings. The DON indicated that Resident #I became upset with Resident #J for wandering into his room and that he was trying to re-direct her when she lost her balance and fell. She also indicated that the resident did not have a history of pushing people and the only behavior he displayed was refusal at times of his mini nebs treatments.</p> <p>One of the Preventative measures listed on the Incident Report was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being.</p> <p>Review of the Social Service and IDT notes indicated follow up 72 hour documentation of the resident's emotional status was lacking until 2/9/15 - 2 days after the incident occurred.</p> <p>5. Review of the clinical record for Resident #J on 2/12/15 at 3:15 p.m.</p>			

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	<p>indicated the resident had diagnoses which included, but were not limited to: dementia with behavior disturbance, Alzheimer's disease, general anxiety disorder, and non-organic psychosis.</p> <p>A 2/9/15 Social Service note indicated "No signs of distress related to altercation with Resident #I who pushed her trying to redirect her when she wandered in to his room, which caused her to fall, no injuries resulted from fall. Observed her today, she was waking (sic) up and down the halls as usual when she is up, easily redirected from entering others rooms, ate meals with staff help in the DR, her appetite remains good. will continue to monitor."</p> <p>On 2/12/15 at 3:53 pm, the DON presented a copy of the 5 Day follow up report to the 2/7/15 incident between this resident and another male resident. Review of this report indicated this resident had been wandering up and down the halls and had wandered into the male resident's room and was observed going thru his belongings. The male resident shoved the female resident causing her to fall but no injuries were observed.</p> <p>In an interview with the DON at this time, she indicated that the resident was</p>			

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	<p>on the go wandering daily up and down the halls and was able to be re-directed without a problem. She indicated this time Resident #J just seemed to pick a room she thought was hers while the actual resident of the room happened to be in it.</p> <p>One of the Preventative measures listed on the Incident Report was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being.</p> <p>Review of the Social Service and IDT notes indicated follow up 72 hour documentation of the resident's emotional status was lacking until 2/9/15 - 2 days after the incident occurred.</p> <p>On 2/12/15 at 1:20 p.m., Memory Care Facilitator indicated he personally monitored and documented the residents after an incident for several days as long as needed. Memory Care Facilitator failed to do this according to documentation for Residents #C, #H, #G, # I, and #J.</p> <p>On 2/9/15 at 9:30 a.m., the Administrator presented a copy of the facility's current policy titled "Abuse Prohibition, Reporting, and Investigation". Review of this policy at this time included, but was</p>			

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F 250 SS=E Bldg. 00	<p>not limited to: "It is the policy of (Name of Corporation) to protect residents from abuse including physical abuse, ...verbal abuse, mental abuse...Policy/Procedure:...10. Supervisory personnel are responsible to monitor, through observation and counseling as needed...and the provision of care and services to the resident...Resident-To-Resident Abuse:...Procedure: If resident-to-resident abuse is identified...the following guidelines will be followed:...9. Follow up assessments will be completed/documented every shift until the resident (s) is stable, and resident safety is maintained..."</p> <p>This Federal tag is related to Complaint IN00164413.</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related Social Services to 5 of 8 residents reviewed for</p>	F 250	F250 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	03/12/2015

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	<p>resident-to-resident altercations in that documentation of follow up after the altercations was not complete or completed in a timely manner. (Residents #C, #H, #G, #I, #J)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #C on 2/12/2015 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: depressive disorder, dementia, and insomnia.</p> <p>On 2/12/15 at 2:45 p.m., the Director of Nursing (DON) presented a copy of an "Incident Report Form" to State regarding an incident in which Resident #B hit Resident #C with a wooden object. Resident #C had bruising and swelling to the right hand, laceration to the top of the head, laceration behind right ear, and hematoma above the right eye. The "Incident Report Form" indicated the immediate action taken was an assessment was completed and Resident #C was sent to the emergency room for evaluation and treatment. Resident #B had increased agitation and was one on one until the police arrived. The "Incident Report Form" indicated the preventive measures taken were Resident #B was removed from the facility and</p>		<p>Residents B and C no longer residesat the facility. Residents H, G, I, and J affected bythe deficient practice have been identified by the interdisciplinary team andhave had their follow up for emotional and psychosocial distress. All careplans and cna assignment sheets have been updated. 2. How will you identify other residentshaving the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. 100% audit completed by SS/DNS for resident to resident altercations will be completed by 3/12/2015 to ensure all follow up documentation completed per protocol. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practicedoes not occur? SS and MCF re educated on resident to resident altercations protocol on 3/6/15 by CEC and DNS. DNS/Designee will review SS notes during clinical meeting to ensure appropriate follow up is provided and followup on. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. To ensure compliance, theSS/MCF/Designee is responsible for the completion of the resident to residentaltercation</p>		

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	<p>was not readmitted. Also the Memory Care Facilitator or designee will follow up with Resident # C for seventy two hours for any signs or symptoms of distress noted.</p> <p>Review of the progress notes for Resident #C on 2/12/2015 at 10:10 a.m., indicated when the resident returned from hospital on 01/23/2015 was visited by the Memory Care Facilitator and was not seen again by the Memory Care Facilitator until 01/26/2015.</p> <p>2. Review of the clinical record for Resident #H on 2/12/15 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia and Alzheimer's.</p> <p>On 2/11/15 at 1:42 p.m., the DON presented a copy of an "Incident Report Form" to State regarding an incident reported to her by Resident #E that a few weeks ago Resident #H rolled her w/c over to Resident #G and Resident #G yelled at her.</p> <p>On 2/11/15 at 2:05 p.m., a staff interview with both the DON and Assistant DON indicated, "Resident #E does not like Resident #G so he's always trying to start something with her. She is loud due to being hard of hearing and she just</p>		<p>CQI tool daily times 2 weeks, then weekly times 12 weeks, then monthly times 6 months to ensure preventative measures are in place. If threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p>		

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	<p>sometimes talks out loud even if no one is there - talks to herself and she does get bossy at times and will say things like it is. He does not like that."</p> <p>On 2/11/15 at 2:05 p.m., the DON presented another "Incident Report Form" to State in which all 3 residents were involved in the same issue again. Resident #E reported Resident #G yelled and cussed at Resident #H when Resident #H rolled her w/c over to #G and got too close.</p> <p>One of the Preventative measures listed on both reports was for Social Services to follow up times 72 hours in order to monitor Resident #H's psychosocial well being and for signs of emotional distress after the incident.</p> <p>Review of the Social Service notes failed to locate documentation of the resident being monitored for emotional distress and well-being - until 2/13/15 - 2 days after the incident occurred.</p> <p>On 2/12/15 at 2:30 p.m., the Social Worker indicated that after an altercation or incident between 2 residents, she monitored and documented on residents at least weekly only unless they needed more. Documentation of this monitoring was lacking on Residents #H and #G.</p>			

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	<p>3. Review of the clinical record for Resident #G on 2/12/15 at 10:30 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia with behaviors, mild intellectual disabilities, depression and intermittent explosive disorder.</p> <p>On 2/11/15 at 1:42 p.m., the DON presented a copy of an "Incident Report Form" to State regarding an incident reported to her by Resident #E that a few weeks ago Resident #H rolled her w/c over to Resident #G and Resident #G yelled at her.</p> <p>On 2/11/15 at 2:05 p.m., a staff interview with both the DON and Assistant DON indicated, "Resident #E does not like Resident #G so he's always trying to start something with her. She is loud due to being hard of hearing and she just sometimes talks out loud even if no one is there - talks to herself and she does get bossy at times and will say things like it is. He does not like that."</p> <p>On 2/11/15 at 2:05 p.m., the DON presented another "Incident Report Form" to State in which all 3 residents were involved in the same issue again. Resident #E reported Resident #G yelled and cussed at Resident #H when Resident</p>			

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	<p>#H rolled her w/c over to #G and got too close.</p> <p>One of the Preventative measures listed for Resident #G on the Incident report was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being and for signs and symptoms of emotional distress after the incident.</p> <p>Review of the Social Service notes for Resident #G failed to locate documentation of the resident being monitored for emotional distress until 2/13/15 - 2 days after the incident occurred.</p> <p>4. Review of the clinical record for Resident #I on 2/13/15 at 10:22 am, indicated the resident had diagnoses which included, but were not limited to: paranoid state and dementia with behavioral disturbance.</p> <p>A 2/9/15 note by Social Services indicated "IDT (Interdisciplinary Team) review related to resident was aggressive toward other resident who wandered in to his room when he tried to redirect her he pushed her and she fell (sic), no injuries sustained related to fall. resident denied being in pain or having unmet needs, he just finished a course of ATB (antibiotic)</p>				

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	<p>related to cold, UA (Urinalysis) and labs ordered per MD (physician), to rule out infection as a route (sic) cause. The route (sic) cause of his bc (behaviors) appears to be the wandering of the other resident in his room. Will ensure his door is shut to help prevent other resident from wandering in to his room."</p> <p>On 2/12/15 at 3:53 p.m., the DON presented the 5 day f/u report that was sent to the State on a 2/7/15 incident between this resident and another resident due to the resident wandering into his room and going through his belongings. The DON indicated that Resident #I became upset with Resident #J for wandering into his room and that he was trying to re-direct her when she lost her balance and fell.</p> <p>One of the Preventative measures listed on the report for Resident # I was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being and signs and symptoms of emotional distress.</p> <p>Review of the Social Service notes for Residents # I indicated follow up 72 hour documentation of the resident's emotional status and well-being was lacking until 2/9/15 - 2 days after the incident occurred.</p>			

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	<p>5. Review of the clinical record for Resident #J on 2/12/15 at 3:15 p.m. indicated the resident had diagnoses which included, but were not limited to: dementia with behavior disturbance, Alzheimer's disease, general anxiety disorder, and non-organic psychosis.</p> <p>A 2/9/15 Social Service note indicated "No signs of distress related to altercation with Resident #I who pushed her trying to redirect her when she wandered in to his room, which caused her to fall, no injuries resulted from fall. observed her today, she was waking (sic) up and down the halls as usual when she is up, easily redirected from entering others rooms, ate meals with staff help in the DR, her appetite remains good. will continue to monitor."</p> <p>On 2/12/15 at 3:53 pm, the DON presented a copy of the 5 Day follow up report to the 2/7/15 incident between this resident and another male resident. Review of this report indicated this resident had been wandering up and down the halls and had wandered into the male resident's room and was observed going thru his belongings. The male resident shoved the female resident causing her to fall but no injuries were observed.</p>			

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	<p>In an interview with the DON at this time, she indicated that the resident was on the go wandering daily up and down the halls and was able to be re-directed without a problem. She indicated that this time she just seemed to pick a room she thought was hers while the actual resident of the room happened to be in it.</p> <p>One of the Preventative measures listed on the report was for Social Services to follow up times 72 hours in order to monitor the resident's psychosocial well being and signs and symptoms of emotional distress.</p> <p>Review of the Social Service and IDT notes indicated follow up 72 hour documentation of the resident's emotional status was lacking until 2/9/15 - 2 days after the incident occurred.</p> <p>On 2/12/15 at 1:20 p.m., Memory Care Facilitator indicated he personally monitored and documented the residents after an incident for several days as long as needed. Documentation was lacking of this monitoring for Residents #C, #I and #J.</p> <p>On 2/12/15 at 1:30 p.m., the Director of Nursing presented copies of both the Memory Care Coordinator 's 12/18/08</p>			

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F 282 SS=D Bldg. 00	<p>and the Social Worker's 12/4/13 signed "Social Services Director Job Descriptions " . Review of these Job Descriptions at this time included, but were not limited to: "Summary of Position Functions: The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential Position Functions: Assesses each resident's psychosocial needs and develops a plan for providing care. Reviews resident's needs and care plan with progress notes indicating implementation of methods to respond to identified needs...."</p> <p>This Federal tag is related to Complaint IN00164413</p> <p>3.1-34(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer a resident's dementia medication at the</p>	F 282	<p>F282 1.What corrective actions will be accomplished for those residents found to have been</p>	03/12/2015

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	<p>prescribed dosage ordered by the psychiatrist and the re-admission orders from the hospital. This affected 1 of 6 residents reviewed for unnecessary medications. (Resident #I)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #I on 2/12/15 at 3:15 p.m. indicated the resident had diagnoses which included, but were not limited to: dementia with behavior disturbance, Alzheimer's disease, general anxiety disorder, and non-organic psychosis.</p> <p>The November 2014 Monthly Physician Orders indicated the resident had the following: - 10/23/14 - Namenda (for Dementia) 10 mg (milligrams) at bedtime every night.</p> <p>On 11/12/14, the psychiatrist evaluated the resident and increased his dose of Namenda to 5 mg every morning and 10 mg every night times one week, then increase it to 10 mg BID (twice daily) for Dementia.</p> <p>Documentation was lacking on the November 2014 Medication Administration Record (MAR) of the order being added and the medication increased per the psychiatrist's order</p>		<p>affected by the deficient practice? Resident I's Namenda has been dc'd per Physicians request. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. 100% of the medication administration records were audited on 2/28/2015 by the nursing staff, medical records, and unit managers to ensure physician's orders were followed up on. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur?</p> <p>All new admissions and readmission orders are reviewed on the next business day in clinical meeting to ensure all physician orders are put in the medication administration record as prescribed. Any Psychiatrist medication order changes will be given to medical records/designee during their visit, medical records will then ensure nurses receive these orders and they are put in the medication administration record. The medical records coordinator will then file these in their charts once completed. Unit managers will bring all new orders to the clinical meeting to review. All licensed staff, MCF and SS will be re educated by</p>	

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	<p>between 11/12 and 11/30/14.</p> <p>The December 2014 MAR also failed to list the change in the Namenda orders per the psychiatrist between 12/1 and 12/7/14. On 12/7/14, the resident was transferred to the hospital until 12/9/14 when he returned.</p> <p>The 12/9/14 Hospital re-admission orders indicated the resident was to receive Namenda 10 mg twice daily. Review of the December 2014 MAR failed to list the correct dose of Namenda - 10 mg - and only received 5 mg twice daily 12/9 through 12/31/14. The re-admit December 2014 Monthly Physician Orders also listed the wrong dose of Namenda - 5 mg twice daily.</p> <p>The January 2015 Monthly Physician Orders and the MAR continued to list the incorrect dose of Namenda - 5 mg twice daily 1/1 to 1/13/15.</p> <p>On 1/14/15, the psychiatrist visited the resident and changed the resident's Namenda orders to: Increase Namenda to 10 mg every morning and 5 mg every evening times 1 week, then 10 mg BID for Dementia. Documentation was lacking of the new order having been written on a telephone order sheet and the January 2015 MAR changed to reflect the</p>		<p>3/12/15 by CEC/DNS on following admission, readmission order protocol, and on Psychiatrist visits and orders. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, DNS/designee is responsible for the completion of the admission/readmission CQI tool daily times two weeks, weekly times 12 weeks, and then monthly times 6 months to ensure preventative measures are in place. If threshold is of 95% is not achieved, an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p>	

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	<p>new orders 1/14 to 1/31/15.</p> <p>In an interview with the Director of Nursing on 2/17/15 at 3:00 p.m., she indicated that she had checked with her nurses and neither she nor her nurses had seen the new orders or the 1/14/15 psychiatrist visit note since it was sitting on the Memory Care Facilitator's desk until requested that morning.</p> <p>Upon verification with LPN #1 on 2/17/15 at 11:50 a.m., the February 2015 Monthly Physician Orders and the MAR continued to have the wrong dosage of Namenda listed for the resident - 5 mg twice a day - instead of the new orders per the psychiatrist of: Increase Namenda to 10 mg every morning and 5 mg every evening times 1 week, then 10 mg BID for Dementia.</p> <p>She also indicated that when the psychiatrist or physician changes the medications, they either write it on a yellow Telephone Order form or the nurse would and then enter it into the computer.</p> <p>On 2/17/15 at 12:00 p.m., the Assistant Director of Nursing presented a copy of the facility's current policy titled 'Matrix Physician Orders'. Review of this policy at this time included, but was not limited</p>			

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	<p>to: "Matrix Physician Orders: All new orders will be entered into the Matrix Physician Orders by the Nurse receiving the orders. All new physician orders will also be hand written on an appropriate order form and placed into the paper record for auditing and record keeping...b. Physician or Nurse Practitioner order signatures will be maintained either by electronic signature in Matrix or on the paper copy of the order in the paper record... Monthly Order Re-Caps: d. Physician Orders Report (Physician Re-Caps) will be printed monthly...a. Nursing Managers and/or designated nurses will review these physician order report (re-caps) for accuracy, order omissions, and obtain any necessary order clarifications. b. Nursing Managers and/or designated nurses will ensure that all telephone orders from the month prior on physical chart are entered into and correctly match the Matrix Physician Orders Report (re-cap). c. All necessary corrections are to be made at that time on both the paper order AND in Matrix Physicians Orders...."</p> <p>This Federal tag is related to Complaint IN00164413.</p> <p>3.1-35(g)(2)</p>			

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F 315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview the facility failed to follow the policy and procedure when providing incontinence care for 2 of 3 residents (Resident # L and K) observed for incontinence care.</p> <p>Findings include:</p> <p>1. On 02/10/15 at 1:09 p.m., a strong smell of urine was noted upon entering the Resident # L's room. The smell was noted to be stronger over the resident. The resident was asleep.</p> <p>On 02/12/15 at 9:22 a.m., the record review of Resident # L's MDS (Minimum Data Set) OBRA (Omnibus Budget Reconciliation Act) Quarterly Review Assessment, dated 05/12/14 and 01/21/15, indicated Extensive Dependence for most ADLs. Both assessment indicated the resident was</p>	F 315	<p>F315</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents L and K are provided with proper incontinent care per facility policy.</p> <p>2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient practice. 100% audit will be completed by 3/6/15 to verify residents who require incontinent care by DNS/ADNS/Nurse Managers/designee to ensure profile and care plans are updated. Skills validations will be completed on all CNA's by 3/12/15 by CEC/designee for perineal care.</p> <p>3. What measures will be put into</p>	03/12/2015

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	<p>Always incontinent (no episodes of continence voiding) of bowel and bladder. No toileting programs. The 10/23/14 CAAs and Care Planning indicated Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Mood State, Falls, Nutritional Status, Dental Care and Pressure Ulcer.</p> <p>On 02/12/15 at 9:40 a.m., CNA # 1 and CNA # 3 provided incontinence care on the Resident # L. They applied gloves after hand washing and rolled down the resident's brief. Wash cloths were used to wash the resident's anal (rectum/back part) area, first. No redness was noted to the resident's buttocks. The resident's buttocks and anal area were dried. The resident was rolled and the clean brief was fastened without providing pericare to the labial area of the resident. One pair of gloves was worn throughout the care.</p> <p>On 02/12/15 at 2:34 p.m., the DoN # 7 provided a copy of the Policy and Procedure for Incontinence Care. The Policy indicated, but was not limited to, "Females Separate labia and wash urethral area first. Wash between and outside labia in downward strokes. Alternate from side to side- wipe from</p>		<p>placeor what systemic changes you will make to ensure that the deficient practicedoes not occur? Skills validations will be completedon all CNA's by 3/12/15 by CEC/designee for perineal care. DNS/Designee will conduct roundseach shift to ensure appropriate incontinent care is being provided perfacility policy. All licensed staff and cna's will bere educated on incontinent care protocol by 3/12/2015 by CEC/Designee.</p> <p>4. How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place? DNS/Designee is responsible for thecompletion of the perineal care skills validation tool weekly times 12 weeks,then monthly times 6 months, to ensure preventative measures are in place. Ifthreshold of 95% is not achieved, an action plan will be developed. Findingswill be reported in continuous quality improvement every month for a minimum of6 months.</p>	

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	<p>front to back and from center of perineum outward. Use a clean area of the wash cloth. Change wash cloth as needed. (Proceed to # 20)...Clean the anal area from front to back, using a clean area of wash cloth with each wipe. do not re-wipe area, unless using a clean are of the wash cloth. Change wash cloth as needed....Remove gloves. Wash hands. Report any unusual findings to nurse. Document procedure."</p> <p>2. On 12/12/15 at 10:10 a.m., the record review of Resident # K's MDS (Minimum Data Set) OBRA (Omnibus Budget Reconciliation Act) Admission Assessment, dated 09/29/14, indicated the resident was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding), always continent of bowel. No toileting program for bowel or bladder continence. The Active Diagnoses indicated Anemia, Hypertension and Dementia. The CAAs and Care Planning indicated Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer and Dental Care. One the 12/29/14 OBRA Quarterly Review Assessment indicated the resident to be Always incontinent of bladder (no episode of continent voiding). Frequently incontinent of</p>			

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	<p>bowel (2 or more episodes of bowel incontinence, but at least one continent bowel movement). The Active Diagnoses indicated Anemia, Hypertension, Dementia and Depression.</p> <p>On 02/12/15 at 10:15 a.m., Resident # K was provided incontinence care by CNA # 2, CNA # 3 and CNA # 1. The blanket was pulled down and the wet wash cloth was folded with each pass in the anal area first. A fresh washcloth was obtained for each area. The buttocks were dried. The penis and groin areas were washed and dried last. Fresh washcloths were obtained for each side. The resident was covered. The gloves were removed. The same pair of gloves was used for the entire care. The call light was placed at the head of the resident's bed. CNA # 1 washed her hands for 20 seconds. CNA # 3 washed her hand for 22 seconds. CNA # 2 washed her hands for 20 seconds.</p> <p>On 02/12/15 at 10:25 a.m., CNA # 2 indicated she would report any skin issues to the nurse, if found.</p> <p>On 02/12/15 at 2:34 p.m., the DoN # 7 provided a copy of the Policy and Procedure for Incontinence Care. The Policy indicated, but was not limited to, "Males: Pull back foreskin (if male is uncircumcised). Wash and rinse tip of penis in circular motion, starting at</p>			

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F 441 SS=E Bldg. 00	<p>urethra moving outward. Use a clean area of the wash cloth with each wipe. Do not re-wipe area, unless using a clean area of the wash cloth. continue washing down the penis to the scrotum outward....Clean the anal area from front to back, using a clean area of wash cloth with each wipe. do not re-wipe area, unless using a clean are of the wash cloth. Change wash cloth as needed....Remove gloves. Wash hands. Report any unusual findings to nurse. Document procedure."</p> <p>On 02/12/15 at 2:49 p.m., the DoN # 7 indicated the procedure was to wash the labial/penis area first and then the anal area.</p> <p>3.1-41(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>			

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	<p>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. Based on observation, record review and interview, the facility failed to follow the policy and procedure for hand washing and glove use when providing incontinence care and dressing changes for 5 of 5 residents (Resident # D, E, L, M and K) observed.</p>	F 441	<p>F 441</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents D, E, L, M and K are provided with proper incontinent care and dressing changes. Residents D, E, L, M and K affected by the alleged</p>	03/12/2015

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	<p>Findings include:</p> <p>1. On 02/10/15 at 1:09 p.m., a strong smell of urine was noted upon entering the Resident # L's room. The smell was noted to be stronger over the resident. The resident was asleep.</p> <p>On 02/12/15 at 9:40 a.m., CNA # 1 and CNA # 3 provided incontinence care on the Resident # L. They applied gloves after hand washing and rolled down the resident's brief to provide care. One pair of gloves was worn throughout the care. The CNAs washed their hands for 12 seconds each.</p> <p>On 02/12/15 at 2:49 p.m., the DoN # 7 indicated proper hand washing would involve washing hands while singing Happy Birthday. After looking at the Hand Washing Policy on her computer, she indicated hands should be washed for 20 seconds. She also indicated the gloves should be changed dirty to clean.</p> <p>2. On 02/12/15 at 10:15 a.m., Resident # K was provided incontinence care by CNA # 2, CNA # 3 and CNA # 1. The CNAs indicated they had washed their hands. Gloves were applied. Incontinence care was provided to the resident. The gloves were removed. The same pair of gloves was used for the</p>		<p>deficient practice have been identified by the Interdisciplinary team and have had no negative outcomes from this alleged deficient practice. Care plans and cna assignment sheets have been reviewed and updated. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All licensed staff, and cna's will be re educated on incontinent care, glove use, dressing changes, and glove use by 3/12/15 100% audit will be completed by 3/6/15 to verify residents who require incontinent care addressing changes by DNS/ ADNS/Nurse Managers/designee. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct rounds each shift to ensure appropriate incontinent care and handwashing is provided per facility policy. All licensed staff, and cna's will be re educated on incontinent care, glove use, dressing changes, and glove use by 3/12/15 CEC/Designee will conduct skills validations check off for all cna's, licensed staff by 3/12/2015 on incontinent care, glove use,</p>		

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	<p>entire care.</p> <p>3. On 02/12/15 at 9:56 a.m., CNA # 3 and CNA # 2 provided incontinence care on the Resident # M. The CNAs indicated they had washed their hands. They applied gloves and provided incontinence care on the resident. One pair of gloves was worn throughout care. CNA # 3 washed her hands for 17 seconds. CNA # 2 washed her hands for 12 seconds.</p> <p>On 02/12/15 at 10:08 a.m., CNA # 2 indicated when she washed her hands: "The sink is turned on. Wash for 30 seconds, I think. Dry towels to dry your hands. Use towels to turn off the water."</p> <p>4. On 02/12/15 at 10:50 a.m., RN # 6 provided wound care on Resident # E's right heel. She pulled granulex, kerlix, tape, an ABD pad, gauze and wound cleanser from the treatment cart. She indicated the wound was not open. She washed her hands for 11 seconds. The RN sat on the floor using her right gloved hand to balance herself on the floor as she sat. She removed the resident's shoe and the kerlix. The tissue at the edge of the wound was peeling. It was 2.0 by 2.2 cm and dark red in color. She cleansed the wound with the cleanser and gauze. Sprayed the granulex on the abd pad and</p>		<p>dressing changes, and glove use.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/designee will daily utilize the Infection control review and skin management program review CQI tool times 2 weeks, then weekly times 12 weeks, then monthly times 6 months to ensure preventative measures in place. If threshold of 95% is not achieved, an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p>	

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	<p>rubbed granulex on the wound with her left gloved hand and applied the ABD pad and wrapped the kerlix around it and the foot. The dressing was dated and the shoe was replaced per the resident's request. The RN removed her gloves and washed her hands for 22 seconds. The garbage was removed from the room.</p> <p>5. On 02/17/15 at 2:55 p.m., RN # 5 brought supplies into the Resident #D's room to provide wound care on the resident. She washed her hands for 5 seconds. She set up the supplies, moved the trash can away from her feet and washed her hands again for 2 seconds. The right lower calf was exposed by removing the pressure boot. The wound was located on the right lower calf area. The RN washed her hands again for 5 seconds and applied gloves. The wound cleanser was applied to the gauze and the wound was washed. The RN again washed her hands for 5 seconds. She applied fresh gloves. The resident's bilateral calves were light brown in color with dry scaly skin. The fresh dressing was applied. The RN removed her gloves. She washed her hands for 9 seconds and applied fresh gloves. RN # 6 and LPN #4, assisting the RN, removed the left boot. The RN removed the old dressing from the wounds to the left ball of foot and the lateral bottom of the left</p>			

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	<p>foot. The 2 areas to the bottom of the foot had black eschar on the wounds. The RN removed her gloves and washed her hands for 5 seconds. She applied fresh gloves. Wound cleanser was sprayed on the gauze to clean the wounds. She washed her hands for 4 seconds after cleaning the wounds with the gauze. She opened the dressing packaging, dated and initialed the dressing and applied Santyl cream onto the swabs and onto the wounds. She then applied the dressing. She removed her gloves and washed her hands for 4 seconds. The left boot was applied by Jenny Rogers, RN. The RN applied fresh gloves. She removed the dressing from left knee and washed her hands for 10 seconds. The wound was circular and the size of a pencil eraser with a small amount of eschar to half of the wound. There was slight redness around the wound. The cleanser was applied to the gauze and the wound was cleaned. She removed her gloves and washed her hands for 9 seconds. She applied fresh gloves. The Santyl cream was applied to the wound with a swab. Fresh dressing was applied to the wound. The RN removed her gloves and washed her hands for 5 seconds. She applied fresh gloves. Normal saline was applied to the kerlix times 2. She removed her gloves and washed her hands for 4 seconds She</p>			

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	<p>applied fresh gloves. The resident was rolled to his right side. The old packing was removed. She removed her gloves and washed her hands for 4 seconds. She applied fresh gloves and applied the wound cleanser to 4 gauze and cleaned the sacral area and the packing was applied into the wound. ABD pads times 4 were applied. She removed her gloves and washed her hands for 5 seconds. She applied fresh gloves. The resident was rolled to his left side, the packing was applied to remaining sacral area wound, and ABD pads were used to cover the remaining wound. Clean chucks were placed under the resident as he was rolled from side to side. The RN removed her gloves and washed her hands for 8 seconds.</p> <p>On 02/12/15 at 2:34 p.m., the DoN # 7 provided a copy of the Policy and Procedure for Hand Washing. The Policy indicated to:</p> <ol style="list-style-type: none"> 1. Turn on water. 2. Adjust temperature (Water should be warm not hot). 3. Angle arms down, holding hands lower than your elbows. 4. Apply soap, rub hand together, between fingers to create a lather. 5. Lather all surfaces of fingers and hands including wrists. 6. Use friction for at least 20 seconds. 			

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F 514	<p>7. clean nails by rubbing palms on other hand.</p> <p>8. Rinse hands, fingers, and wrists thoroughly holding downward.</p> <p>9. Use a clean paper towel to pat dry all hands, fingers, and wrists.</p> <p>10. Turn off faucet with paper towel and discard paper towel immediately.</p> <p>On 02/12/15 at 2:49 p.m., the DoN # 7 indicated proper hand washing would involve washing hands while singing Happy Birthday. After looking at the Hand Washing Policy on her computer, she indicated hands should be washed for 20 seconds. She also indicated the gloves should be changed dirty to clean.</p> <p>This Federal tag is related to Complaint IN00163649.</p> <p>3.1-18(1)</p>				
	483.75(l)(1)				

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SS=D Bldg. 00	<p>RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>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 interviews, the facility failed to ensure psychiatric visit notes were available and organized in the clinical record and changes in medications were complete and documented to ensure the resident received the correct dosage of Dementia medication for 1 of 8 residents reviewed for psychiatric services. (Resident #1)</p> <p>Finding includes:</p> <p>During record review for Resident #I on 2/13/15 at 10:30 a.m., the last Psychiatrist visit note in the chart was dated 11/12/14. Upon request to the Memory Care Facilitator at this time for any psychiatric visit notes after this date, the Memory Care Facilitator was observed to go to his office and bring out the note which he indicated was in his</p>	F 514	<p>F 514</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident I that was affected by the alleged practice have been identified by the interdisciplinary team. The physician was notified and Namenda was dc'd. All psychiatrist visits have been filed in the chart accordingly.2. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. DNS/designee will audit 100% of residents charts who have Psych services to ensure all psych visits and orders are in place by 3/12/15. 3. What measures will be put into place or what systemic changes you will make to ensure that the</p>	03/12/2015			

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	<p>office on his desk for some reason.</p> <p>In an interview with the Memory Care Facilitator on 2/17/15 at 11:55 a.m., he indicated that when the psychiatrist writes his/her progress notes, they would be given to the nurse and they were responsible for updating the new orders and for filing them in the clinical record. He indicated that Resident #I's 1/14/15 visit note was the only one missing that he had in his office.</p> <p>During an interview with the Director of Nursing on 2/17/15 at 3:00 p.m., she indicated that there was no one specifically responsible for filing the psychiatric notes on the clinical record, but that it usually was the Social Workers who put them on the clinical records as they were the ones to receive the notes when the psychiatrist visited.</p> <p>On 1/14/15, the psychiatrist visited and changed the resident's Dementia medication - Namenda to "Increase Namenda to 10 mg (milligrams) every morning and 5 mg every Night times 1 week and then give 10 mg BID (twice daily)". Review of the January and February 2015 Monthly and Telephone Physician Orders failed to reflect these changes.</p>		<p>deficient practice does not occur? SS, MCF, and all licensed staff will be re educated on physician visits by 3/12/15. Resident's charts that receive psych services will be reviewed by Medical records/SS/ MCF/Designee to ensure psych progress notes are in the chart during clinical meeting.</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/designee will daily utilize the physician services CQI tool times 2 weeks, then weekly times 12 weeks, then monthly times 6 months to ensure preventative measures are in place. If threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p>	

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	<p>The Director of Nursing also indicated on 2/17/15 at 3:00 p.m., that she checked with her nurses and neither she nor her nurses had seen the new orders or the 1/14/15 psychiatrist visit note.</p> <p>This Federal tag is related to Complaint IN00164413.</p> <p>3.1-50(a) 3.1-50(b) 3.1-50(c) 3.1-50(d)</p>				