

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 15, 16, 17, 18, and 19, 2016</p> <p>Facility number: 000224 Provider number: 155331 AIM number: 100267700</p> <p>Census bed type: SNF: 19 SNF/NF: 78 Total: 97</p> <p>Census payor type: Medicare: 25 Medicaid: 60 Other: 12 Total: 97</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143 on February 24, 2016.</p>	F 0000	<p>I respectfully request consideration for paper compliance. I have forwarded the signed 2567 via fax today (3-4-16) to 1-317-233-7322. I will also forward all documents, inservices, etc. upon date certain to the same number listed above. Please reference the attached 2567 as "Credible Allegation of Compliance" for our annual survey conducted on February 15-19, 2016. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director.</p>	
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</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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	<p>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 provide services in accordance with a resident's written plan of care related to the lack of an assessment and monitoring of a resident with bruises, not following physician's orders for blood pressure parameters and blood pressures not completed as ordered for a blood pressure medication for 3 of 21 residents whose plans of care were reviewed. (Residents #42, #123, #108)</p> <p>Findings include:</p> <p>1. On 2/15/16 at 2:18 p.m., Resident #42 was observed to have dark blue discolorations to the right inner forearm, right outer wrist and top of right hand.</p> <p>On 2/17/16 at 10:47 a.m., Resident #42 was observed lying in bed watching television with dark purple discolorations to the right inner forearm, right outer wrist and top of right hand. Interview with the resident at the time of the observation indicated she had a recent blood draw so maybe that was where the discolorations came from.</p> <p>On 2/17/16 at 9:45 a.m., Resident #42</p>	F 0282	<p>F 282 SS = D</p> <p>1. Blood pressure logs and medication administration records for residents #42, #123, and #108 were reviewed by licensed nursing staff and any inconsistencies with blood pressure monitoring and/or administration of antihypertensive medication were addressed with the attending physician by 2/19/2016. Responsible parties were also advised of the above and the physician's response. Resident #42 had a Skin Integrity Assessment completed by licensed staff on 2/19/2016 and any areas of bruising or skin trauma identified were documented. The physician and responsible party were notified as per policy. Resident #108's Medication Administration Record did indicate nurses' initials for encouraging fluids with medication pass but was amended as of 2/17/2016 to ensure documentation for amount consumed. Physician orders and the care plans for residents #42, #123, and #108 were reviewed by the DON and designees by 3-8-16 to ensure all physician orders and interventions on the plan of care are being followed.</p> <p>2. To identify residents at risk for inconsistencies with blood pressure monitoring and/or administration of antihypertensive</p>	03/16/2016

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	<p>was observed lying in bed with her eyes closed. A dark purple discoloration on the resident's right outer wrist could be observed from the doorway.</p> <p>Record review for Resident #42 was completed on 2/18/16 at 2:08 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, diabetes mellitus, anxiety and depression.</p> <p>A Care Plan indicated the resident was at risk for abnormal bleeding or hemorrhage because of anticoagulation (blood thinning) usage of Aspirin. Interventions included to observe for and report to nurse any signs and symptoms of bleeding which included unusual bruising, and nurses to perform skin assessments at least weekly and record the findings.</p> <p>Review of a Weekly Skin Integrity Data Collection sheet completed on 2/17/16 indicated the residents skin was intact and bruising was not marked.</p> <p>Interview with the Director of Nursing (DON) on 2/19/16 at 11:00 a.m., indicated the bruising on the right wrist was probably from a tourniquet from a blood draw she had earlier in the month, and the bruises on the right hand were probably from the blood draw. She</p>		<p>medications per parameters, administrative nursing staff obtained a listing of all residents on antihypertensive medications and identified those residents with blood pressure monitoring and blood pressure parameter orders. Blood pressure readings and antihypertensive medications were audited by 3/3/2016 to ensure blood pressures were recorded as ordered and medication administration followed physician orders for parameters as indicated. Facility residents on each unit had Skin Integrity Assessments completed by 3/9/2016 to ensure any areas of skin injury or skin breakdown were identified and follow-up was accomplished as necessary per policy. Medical Records staff amended the computerized data entry for the Medication Administration Record to include an area to record amount of fluids consumed with medication pass by 3/1/2016. The DON and designees audited all physician orders and resident care plans to ensure interventions are being followed as per MD orders and specific care planned interventions. Any discrepancies identified were addressed as per policy by 3/8/16.</p> <p>3. The Staff Development Coordinator re-educated identified staff regarding blood pressure documentation and administration of antihypertensive medications per parameters. The</p>		

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	<p>indicated staff should have identified the bruising by now and documented them. She further indicated nursing should have noted the bruising when her skin assessment was completed on 2/17/16.</p> <p>A Care Plan indicated the resident had a potential for complications related to the diagnosis of hypertension. Interventions included to administer medications as ordered, monitor blood pressure and record, and to hold medication as needed and notify the physician.</p> <p>Review of the February 2016 Physician Order Summary indicated the resident had an order for Lopressor (blood pressure medication) 12.5 mg (milligrams) twice daily and to hold if SBP (systolic blood pressure) (top number) was less than 90 or DBP (diastolic blood pressure) (bottom number) is less than 60.</p> <p>Review of the January 2016 MAR (Medication Administration Record) and Blood Pressure and Pulses flow sheet indicated:</p> <p>Blood Pressure (BP) medication administered when out of parameters: 8:00 a.m., - 1/1/16 BP=135/58 8:00 a.m., - 1/6/16 BP=119/54 8:00 p.m., - 1/9/16 BP= 140/58</p>		<p>Staff Development Coordinator also developed an in-service that addresses guidelines for blood pressure monitoring/documentation, administration of antihypertensive medications per parameters, Skin Integrity Assessments and documentation of fluids offered with each medication pass. Education also included following physician orders and the resident care plan. This in-service will be provided to all facility staff by 3/11/2016.</p> <p>4. Using a Blood Pressure and Antihypertensive Parameters Audit Tool, a Skin Integrity Assessment Audit Tool and a Fluids Offered at Medication Pass Audit Tool, the DON and/or designees will perform audits three times weekly for six months to monitor compliance. Additionally, a Physician Order/Care Plan Audit Tool was developed to be used for weekly audits of physician orders and resident care plans by the DON or designee to ensure all physician orders are followed and that care planned interventions remain appropriate and are followed by nursing staff. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QA/QI meeting and an action plan will be developed for any negative trends. Criteria for determining that monitoring is no longer necessary will be 95%</p>	

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	<p>8:00 a.m., - 1/19/16 BP= 110/58</p> <p>BP not taken before medication administered:</p> <p>8:00 p.m., 1/2/16 8:00 p.m., 1/5/16 8:00 p.m., 1/7/16 8:00 p.m., 1/8/16 8:00 a.m., 1/9/16 8:00 p.m., 1/10/16 8:00 p.m., 1/12/16 8:00 p.m., 1/13/16 8:00 p.m., 1/14/16 8:00 a.m., & 8:00 p.m., 1/17/16 8:00 p.m., 1/21/16 8:00 p.m., 1/28/16 8:00 p.m., 1/31/16</p> <p>Review of the February 2016 MAR and Blood Pressure and Pulses flow sheet indicated:</p> <p>BP medication administered when out of parameters:</p> <p>8:00 a.m., - 2/2/16 BP=112/58 8:00 p.m., - 2/2/16 BP=126/58 8:00 a.m., - 2/5/16 BP= 106/59 8:00 p.m., - 2/6/16 BP= 136/56</p> <p>BP not taken before medication administered:</p> <p>8:00 p.m., 2/1/16 8:00 a.m., 2/8/16 8:00 p.m., 2/9/16</p>		<p>accuracy. If audits do not meet this criteria, audits will continue for an additional six months at the current schedule. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 3-16-16</p>	

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	<p>8:00 p.m., 2/10/16 8:00 p.m., 2/11/16 8:00 p.m., 2/12/16 8:00 p.m., 2/13/16 8:00 p.m., 2/15/16 8:00 a.m., 2/16/16</p> <p>Interview with the DON on 2/19/16 at 1:25 p.m., indicated she was unable to find any documentation the BP's were taken on the above dates when the medication was administered and the BP medications should have not been administered on the above dates and times when it was out of the parameters.</p> <p>2. The record for Resident #123 was reviewed on 2/17/16 at 1:06 p.m. The resident's diagnoses included, but were not limited to hypertension, cardiac arrhythmia, and heart disease.</p> <p>Review of the 2/2016 Physician Order Summary indicated an order for carvedilol (Coreg, a blood pressure medication) 12.5 milligrams (mg) twice daily with meals, hold if SBP (systolic blood pressure) was less than 100 and call MD (physician). There was also an order for nifedipine (Procardia, a blood pressure medication) ER (extended</p>			

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	<p>release) daily at bedtime, hold if SBP was less than 100 and call MD.</p> <p>Review of the Blood Pressures and Pulses flow sheet for 1/2016 indicated there were no blood pressure obtained before the medications were administered on the following dates:</p> <p>1/1/16 7-3 shift 1/2/16 7-3 shift 1/3/16 7-3 shift 1/4/16 7-3 shift 1/5/16 7-3 shift 1/7/16 7-3 shift 1/8/16 7-3 shift and 3-11 shift 1/10/16 3-11 shift 1/12/16 3-11 shift 1/13/16 3-11 shift 1/14/16 3-11 shift 1/17/16 3-11 shift 1/21/16 3-11 shift 1/23/16 3-11 shift 1/25/16 3-11 shift</p> <p>Review of the 1/2016 Medication Administration Record (MAR) indicated the resident had received the carvedilol medication twice a day and the nifedipine medication daily.</p> <p>The resident had a care plan for potential for complications related to diagnosis of hypertension. The nursing approaches included "...monitor b/p (blood pressure)</p>			

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	<p>as ordered and record, hold medication as ordered as needed and notify md (physician)..."</p> <p>Interview with the Director of Nursing (DON) on 2/19/16 at 9:55 a.m. indicated the blood pressures should have been documented on the flow sheet.</p> <p>3. The record for Resident #108 was reviewed on 2/17/16 at 8:47 a.m. The resident's diagnoses included, but were not limited to, heart disease, chronic kidney disease(stage 3), hemiplegia and hemiparesis (paralyzed on one side of the body) and retention of urine. The resident was re-admitted into the facility on 2/11/16.</p> <p>Review of the current Physician's Order Summary (POS) indicated to give Coreg (a blood pressure reducing medication) 12.5 mg (milligrams), by mouth, twice a day. Hold if SBP (Systolic Blood Pressure) less than 100 and call the Physician. The medication was scheduled for 9 a.m. and 9 p.m. on the February 2016 MAR (Medication Administration Record).</p> <p>Review of the resident's Nurse Notes, 2/11/16 through 2/17/16, from the 8-10 p.m. time frame, indicated a lack of documentation of the resident's second</p>			

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	<p>blood pressure taken each day.</p> <p>Review of the resident's "Blood Pressures and Pulses" flow sheet, indicated a lack of a second blood pressure taken each day.</p> <p>Review of the February 2016 MAR indicated the resident received the medication Coreg 12.5 mg on 2/12, 2/13, 2/14, and 2/15 at 9 p.m. as ordered. The medication's order date was 2/11/16.</p> <p>Interview with the Unit Manager on the Rehabilitation Hall on 2/17/16 at 11:00 a.m., indicated the nurse should have taken the resident's blood pressure twice a day, just before giving the medication.</p> <p>Review of the current POS indicated to offer fluids with each medication pass and to record the amount consumed each shift.</p> <p>Review of the resident's February 2016 MAR lacked an indication that the resident was offered fluids with each medication pass. The order was dated 2/11/16.</p> <p>Interview with the Unit Manager on the Rehabilitation Hall on 2/17/16 at 11:40 a.m., indicated the Physician's Order was not documented on the resident's</p>			

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F 0309 SS=D Bldg. 00	<p>February MAR and should have been.</p> <p>3.1-35(g)(1)</p> <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 each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 6 residents who met the criteria for non pressure related skin conditions. (Resident #42)</p> <p>Finding includes:</p>	F 0309	<p>F 309 SS= D 1.Resident #42 had a Skin Integrity Assessment completed by licensed staff on 2/19/2016 and any areas of bruising or skin trauma identified were documented and addressed. The physician and responsible party were notified as per policy. 2.Facility residents on each unit had Skin Integrity Assessments completed by 3/9/2016 to ensure any areas of skin injury or skin breakdown were identified and follow-up was accomplished as</p>	03/16/2016

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	<p>On 2/15/16 at 2:18 p.m., Resident #42 was observed to have dark blue discolorations to the right inner forearm, right outer wrist and top of right hand.</p> <p>On 2/17/16 at 10:47 a.m., Resident #42 was observed lying in bed watching television with dark purple discolorations to the right inner forearm, right outer wrist and top of right hand. Interview with the resident at the time of the observation indicated she had a recent blood draw so maybe that was where the discolorations came from.</p> <p>On 2/17/16 at 9:45 a.m., Resident #42 was observed lying in bed with her eyes closed. A dark purple discoloration on the resident's right outer wrist could be observed from the doorway.</p> <p>Record review for Resident #42 was completed on 2/18/16 at 2:08 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, diabetes mellitus, anxiety and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 12/11/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 11 which indicated the resident's cognition was moderately impaired. The</p>		<p>necessary per policy.</p> <p>3. The Staff Development Coordinator re-educated identified staff regarding accuracy of Skin Integrity Assessments. The Staff Development Coordinator also developed in-servicing on guidelines for Skin Integrity Assessments. This in-service will be provided to all licensed nursing staff by 3/11/2016.</p> <p>4. Using a Skin Integrity Assessment Audit Tool the DON and/or designees will perform audits three times weekly for six months to monitor compliance. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QA/QI meeting and an action plan will be developed for any negative trends. Criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits will continue for an additional six months at the current schedule. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>DATE CERTAIN 3-16-16</p>	

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	<p>assessment indicated the resident needed an extensive 2+ person assist for bed mobility and transfers; extensive 1 person assist for dressing, toileting and personal hygiene; and physical help of 1 person assist for bathing.</p> <p>A Care Plan indicated the resident was at risk for abnormal bleeding or hemorrhage because of anticoagulation (blood thinning) usage of aspirin. Interventions included to observe for and report to nurse any signs and symptoms of bleeding which included unusual bruising, and nurses to perform skin assessments at least weekly and record the findings.</p> <p>Review of the February 2016 Physician Order Summary indicated the resident received Ecotrin Low Strength (aspirin, anti-inflammatory and blood thinner) 81 mg (milligrams) daily.</p> <p>Review of a Weekly Skin Integrity Data Collection sheet completed on 2/17/16 indicated the residents skin was intact and bruising was not marked.</p> <p>Interview with the Director of Nursing (DON) on 2/19/16 at 11:00 a.m., indicated the bruising on the right wrist was probably from a tourniquet from a blood draw she had earlier in the month,</p>			

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F 0329 SS=D Bldg. 00	<p>and the bruises on the right hand were probably from the blood draw. She indicated staff should have identified the bruising by now and documented them. She further indicated nursing should have noted the bruising when her skin assessment was completed on 2/17/16.</p> <p>3.1-37(a)</p> <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,</p>	F 0329	F 329 SS = D	03/16/2016	

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	<p>the facility failed to ensure residents were free from unnecessary medications, related to blood pressure parameters not followed and blood pressures not completed as ordered for a blood pressure medication, and fluids not offered with medication pass as ordered for 3 of 5 residents reviewed for unnecessary medications. (Residents #42, #123, #108)</p> <p>Findings include:</p> <p>1. Record review for Resident #42 was completed on 2/18/16 at 2:08 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, diabetes mellitus, anxiety and depression.</p> <p>A Care Plan indicated the resident had a potential for complications related to the diagnosis of hypertension. Interventions included to administer medications as ordered, monitor blood pressure and record, and to hold medication as needed and notify the physician.</p> <p>Review of the February 2016 Physician Order Summary indicated the resident had an order for Lopressor (blood pressure medication) 12.5 mg (milligrams) twice daily and to hold if SBP (systolic blood pressure) (top number) was less than 90 or DBP (diastolic blood pressure) (bottom</p>		<p>1. Blood pressure logs and medication administration records for residents #42, #123, and #108 were reviewed by licensed nursing staff and any inconsistencies with blood pressure monitoring and/or administration of antihypertensive medication were addressed with the attending physician by 2/19/2016. Responsible parties were also advised of the above and the physician's response.</p> <p>2. To identify residents at risk for inconsistencies with blood pressure monitoring and/or administration of antihypertensive medications per parameters, administrative nursing staff obtained a listing of all residents on antihypertensive medications and identified those residents with blood pressure monitoring and blood pressure parameter orders. Blood pressure readings and antihypertensive medications were audited by 3/4/2016 to ensure blood pressures were recorded as ordered and medication administration followed physician orders for parameters as indicated.</p> <p>3. The Staff Development Coordinator re-educated identified staff regarding blood pressure documentation and administration of antihypertensive medications per parameters. The Staff Development Coordinator also developed an in-service that addresses guidelines for blood pressure monitoring and</p>	

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	<p>number) was less than 60.</p> <p>Review of the January 2016 MAR (Medication Administration Record) and Blood Pressure and Pulses flow sheet indicated:</p> <p>Blood Pressure (BP) medication administered when out of parameters: 8:00 a.m., - 1/1/16 BP=135/58 8:00 a.m., - 1/6/16 BP=119/54 8:00 p.m., - 1/9/16 BP= 140/58 8:00 a.m., - 1/19/16 BP= 110/58</p> <p>BP not taken before medication administered: 8:00 p.m., 1/2/16 8:00 p.m., 1/5/16 8:00 p.m., 1/7/16 8:00 p.m., 1/8/16 8:00 a.m., 1/9/16 8:00 p.m., 1/10/16 8:00 p.m., 1/12/16 8:00 p.m., 1/13/16 8:00 p.m., 1/14/16 8:00 a.m., & 8:00 p.m., 1/17/16 8:00 p.m., 1/21/16 8:00 p.m., 1/28/16 8:00 p.m., 1/31/16</p> <p>Review of the February 2016 MAR and Blood Pressure and Pulses flow sheet indicated:</p>		<p>documentation as well as administration of antihypertensive medications per parameters and licensed nursing staff were in-serviced on this material by 3/11/16.</p> <p>4. Using a Blood Pressure and Antihypertensive Parameters Audit Tool, the DON and/or designees will perform audits three times weekly for six months to monitor compliance. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QA/QI meeting and an action plan will be developed for any negative trends. Criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits will continue for an additional six months at the current schedule. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>DATE CERTAIN 3-16-16</p>		

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	<p>BP medication administered when out of parameters: 8:00 a.m., - 2/2/16 BP=112/58 8:00 p.m., - 2/2/16 BP=126/58 8:00 a.m., - 2/5/16 BP= 106/59 8:00 p.m., - 2/6/16 BP= 136/56</p> <p>BP not taken before medication administered: 8:00 p.m., 2/1/16 8:00 a.m., 2/8/16 8:00 p.m., 2/9/16 8:00 p.m., 2/10/16 8:00 p.m., 2/11/16 8:00 p.m., 2/12/16 8:00 p.m., 2/13/16 8:00 p.m., 2/15/16 8:00 a.m., 2/16/16</p> <p>Interview with the DON on 2/19/16 at 1:25 p.m., indicated she was unable to find any documentation the BP's were taken on the above dates when the medication was administered and the BP medications should have not been administered on the above dates and times when it was out of the parameters.</p> <p>2. The record for Resident #123 was reviewed on 2/17/16 at 1:06 p.m. The resident's diagnoses included, but were not limited to hypertension, cardiac</p>			

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	<p>arrhythmia, and heart disease.</p> <p>Review of the 2/2016 Physician Order Summary indicated an order for carvedilol (Coreg, a blood pressure medication) 12.5 milligrams (mg) twice daily with meals, hold if SBP (systolic blood pressure) was less than 100 and call MD (physician). There was also an order for nifedipine (Procardia, a blood pressure medication) ER (extended release) daily at bedtime, hold if SBP was less than 100 and call MD.</p> <p>Review of the Blood Pressures and Pulses flow sheet for 1/2016 indicated there was no blood pressure obtained before the medications were administered on the following dates:</p> <p>1/1/16 7-3 shift 1/2/16 7-3 shift 1/3/16 7-3 shift 1/4/16 7-3 shift 1/5/16 7-3 shift 1/7/16 7-3 shift 1/8/16 7-3 shift and 3-11 shift 1/10/16 3-11 shift 1/12/16 3-11 shift 1/13/16 3-11 shift 1/14/16 3-11 shift 1/17/16 3-11 shift 1/21/16 3-11 shift 1/23/16 3-11 shift 1/25/16 3-11 shift</p>			

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	<p>Review of the 1/2016 Medication Administration Record (MAR) indicated the resident had received the carvedilol medication twice a day and the nifedipine medication daily.</p> <p>Interview with the Director of Nursing (DON) on 2/19/16 at 9:55 a.m. indicated the blood pressures should have been documented on the flow sheet.</p> <p>3. The record for Resident #108 was reviewed on 2/17/16 at 8:47 a.m. The resident's diagnoses included, but were not limited to, heart disease, chronic kidney disease, stage 3, hemiplegia and hemiparesis (paralyzed on one side of the body) and retention of urine. The resident was re-admitted into the facility on 2/11/16.</p> <p>Review of the current Physician's Order Summary (POS) indicated to give Coreg (a blood pressure reducing medication) 12.5 mg (milligrams), by mouth, twice a day. Hold if SBP (Systolic Blood Pressure) less than 100 and call the Physician. The medication was scheduled for 9 a.m. and 9 p.m. on the February 2016 MAR (Medication Administration Record).</p> <p>Review of the resident's Nurse Notes,</p>			

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F 0363 SS=E Bldg. 00	<p>2/11/16 through 2/17/16, from the 8-10 p.m. time frame, indicated a lack of documentation of the resident's second blood pressure taken each day.</p> <p>Review of the resident's "Blood Pressures and Pulses" sheet, indicated a lack of a second blood pressure taken each day.</p> <p>Review of the February 2016 MAR indicated the resident received the medication Coreg 12.5 mg twice a day on 2/12, 2/13, 2/14, and 2/15 at 9 p.m. as ordered. The medication's order date was 2/11/16.</p> <p>Interview with the Unit Manager on the Rehabilitation Hall on 2/17/16 at 11:00 a.m., indicated the nurse should have taken the resident's blood pressure twice a day, just before giving the medication.</p> <p>3.1-48(a)(6)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the</p>			

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	<p>recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 16 of the 16 residents in the facility who received a puree diet. (Kitchen)</p> <p>Finding includes:</p> <p>On 2/18/16 at 10:10 a.m. during the Chicken Tarragon puree, the following was observed with Cook #1:</p> <p>Cook #1 placed the cooked and cut up Chicken Tarragon into the puree blender, then proceed to add 4 cups of hot water.</p> <p>Review of the Chicken Tarragon recipe indicated 4 ¼ ounce of chicken soup base.</p> <p>Interview with Cook #1 at that time, indicated that the hot water had some chicken juice from the cooked chicken and was added to make the puree an applesauce consistency.</p> <p>Interview with the Director of Food Services on 2/18/16 at 1:24 p.m. indicated Cook #1 did not follow the</p>	F 0363	<p>F 363 SS = E 1. The alleged discrepancy regarding the preparation of the Chicken Tarragon recipe was not identified as an error until after the meal service was complete. 2. The Dietary Manager educated Cook #1 verbally on following the recipe for pureed Chicken Tarragon upon discovery of the concern. The Dietary Manager and Dietician completed an additional inservice on 2-19-16 for additional Dietary staff. 3. The Dietary Manager or designee will audit food preparation for pureed diets three times weekly for six months to ensure recipes are being followed. Any findings will be addressed with immediate re-education and/or discipline. 4. The Executive Director or designee will analyze pureed food audits for trending data monthly and present a report of her findings at the monthly QA/QI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice</p>	03/16/2016

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F 0371 SS=E Bldg. 00	<p>recipe and should have added 4 ¼ ounces of the chicken soup base.</p> <p>3.1-20(i)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to store food under sanitary conditions related improper storage of food in the freezer and the dry storage area for 1 of 1 kitchens. (Kitchen)</p> <p>Finding includes:</p> <p>During the initial tour on 2/15/16 at 9:44 a.m. with the Director of Food Services, the following was observed in the kitchen:</p>	F 0371	<p>does not reoccur and/or adapt audit schedules. DATE CERTAIN 3-16-16</p> <p>F 371 SS = E 1.The identified undated and/or unlabeled items were removed from the food storage areas on 2-15-16. The Dietary Manager did an additional review of all food storage areas to ensure all foods were in closed/sealed containers, labeled, and dated on 2-15-16. 2. The Dietary Manager educated staff on policies related to food storage verbally upon discovery of the concern and again, in writing, by 2-26-16. The Dietician will provide additional education to Dietary staff, as needed regarding food storage by 3-11-16. 3. The Dietary Manager or designee will</p>	03/16/2016	

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	<p>a. In the walk in freezer, all the food was frozen to touch, a bag of small pizzas and breadsticks were unlabeled and undated.</p> <p>b. Also in the walk in freezer, a bag of egg omelets and tator tots were open and exposed to the air, unlabeled and undated.</p> <p>c. In the dry storage area, a bag of closed pasta noodles was unlabeled and without a date. The lid for the dry cereal container was half off the container, exposing the cereal to the air.</p> <p>Interview with the Director of Food Services at that time, indicated all foods should have been closed, labeled and dated.</p> <p>The policy titled, "Food Safety," was provided by the Administrator on 2/17/16 at 8:15 a.m. The current policy indicated, "...Guidelines: Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary...container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container) ...Cold Food Storage:Leftovers are dated properly ...Dry Storage: ...Opened packages of food are resealed tightly to prevent contamination of the food item "</p>		<p>utilize a food storage audit tool to audit food storage areas three times weekly for six months to ensure all food is in closed/sealed containers, labeled and dated. Any findings will be addressed with immediate re-education and/or discipline. 4.The Executive Director or designee will review all audit tools, analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>DATE CERTAIN 3-16-16</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-21(i)(3)			