

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2013
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 22, 23, 24, 25, 26, 29 and 30, 2013</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Lara Richards, RN, TC Kathleen "Kitty" Vargus, RN Cynthia "Cyndy" Stramel, RN (4/22-4/25, 4/29 and 4/30/13)</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 17 Medicaid: 47 Other: 8 Total: 72</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 8, 2013, by Janelyn Kulik, RN.</p>	F000000	<p>May 17, 2013</p> <p>Kim Rhoades, Director of Long-Term Care Indiana State Department of Public Health 2 North Meridian St. Indianapolis, IN 46204</p> <p>Dear Ms Newton,</p> <p>Please reference the enclosed 2567-L as "Plan of Correction" for the April 30, 2013 Rectification and State Licensure Survey that was conducted at Hammond Whiting Care Center.</p> <p>I am respectfully requesting paper compliance for this survey. I will submit signature sheets of in-servicing, content of in-services, and audit tools May 27 th , 2013.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in 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>statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.</p> <p>The Plan of Correction submitted on May 17, 2013 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.</p> <p>Respectfully,</p> <p>Caryn G. Moore RN, MSN Executive Director</p>		

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of a resident's change in condition, related to the onset of lethargy for 1 of 3</p>	F000157	F 157 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #98 was not in the facility	05/30/2013			

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	<p>residents reviewed for death of the 3 residents who met the criteria for death. (Resident #98)</p> <p>Findings include:</p> <p>The closed record for Resident #98 was reviewed on 4/29/13 at 12:45 p.m. The resident was admitted to the facility on 11/8/12.</p> <p>The resident had diagnoses that included, but were not limited to, hypertension, arthritis, anxiety and hypothyroidism.</p> <p>The hospital History and Physical dated 11/2/12, indicated the resident presented to the hospital due to mental confusion. She had been seen in the physician's office on the day prior, secondary to a fall at home. She had a large hematoma on her right leg, and an x-ray was taken but there were no fractures. A CT (computerized tomography) of the head was done, which noted no intracranial pathology, EKG (electrocardiogram) was within normal limits, the chest x-ray was within normal limits and pulse oximetry was 95%. Because of her strange behavior she was admitted to the hospital.</p>		<p>at time of the survey and no longer resides in the facility.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is a review of nursing documentation related to residents who have had a fall within the past 30 days will be completed to ensure any change in condition was properly communicated to both the physician and family. Any issues will be immediately addressed.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Facility staff will be in-serviced by Director of Nursing and /or Staff Development Coordinator in the use of the Interact early warning tool "stop and watch" by 5/24/2013</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit 100% of the completed "stop and watch" tools. DON/designee will verify the follow through was completed related to the identified issues Monday through Friday, weekend issues will be reviewed on Monday. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be</p>		

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	<p>The Therapy Manager was interviewed on 4/30/13 at 9:54 a.m. She indicated when the resident was admitted to the facility she was able to ambulate with minimal assistance. She was evaluated by therapy on Friday, 11/9/12. On Monday, 11/12/12, at the next therapy session, the resident was lethargic and could not ambulate.</p> <p>The Physical Therapy progress notes dated 11/9/12, indicated the resident was able to ambulate with a rolling walker 30 feet. On 11/12/12, the progress note indicated, "Pt.(patient) very lethargic today and unable to arouse." The 11/13/12 Physical Therapy progress note, indicated, "Pt. very lethargic today and unable to arouse."</p> <p>Review of the clinical record indicated there was no evidence that the physician was notified on 11/12/12 or on 11/13/12 of the residents change in status, related to the onset of lethargy.</p> <p>Interview with the Director of Nursing on 4/30/13 at 11:47 a.m., indicated the resident had a change in status on 11/12 /12. She indicated the nursing staff should have notified the Physician on 11/12/12 of the</p>		<p>amended when indicated.</p> <p>5. Completion date systemic changes will be completed is May 30, 2013.</p>				

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	resident's increased lethargy. 3.1-5(a)(2)				

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F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the results of the most recent survey were readily accessible and available. This had the potential to affect the 72 residents residing in the facility.</p> <p>Findings include:</p> <p>Resident #7 was interviewed on 4/30/13 at 1:20 p.m. She indicated she regularly attended the Resident Council meetings. She indicated she was not aware of the location of the results of the most recent survey.</p> <p>Observation of the front lobby on 4/30/13 at 2:02 p.m., indicated there was a sign that stated, "Information: Latest Survey." The sign was posted on the wall, next to a book shelf. The sign did not indicate where the latest survey was. Observation of the book shelf indicated there was no book or</p>	F000167	F 167 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #7 is now aware of the location of the results of the most recent survey.2. The corrective action for those residents having the potential to be affected by the same deficient practice is: No residents were adversely affected due to the deficient practice.3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: The Activity Department has been in-serviced by thee, Executive Director on 5/17/13 to discuss the location of the survey information at each Resident Council Meeting. A new sign was affixed to the wall in the front lobby indicating the location of the survey results.4. To ensure the deficient practice does not reoccur, the monitoring system established is: The receptionist will verify once weekly placement of the survey	05/30/2013	

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	<p>binder with the survey results.</p> <p>Interview with Business Office Staff #1 at that time, indicated the survey results were in a closed drawer of the book shelf.</p> <p>Interview with the Business Manager on 4/30/13 at 2:08 p.m., indicated the survey book used to be on the book shelf, but some of the residents would take it and misplace it.</p> <p>Interview with the Activity Director on 4/30/13 at 2:08 p.m., indicated the Resident Council meets monthly. She indicated she had not reviewed the location of the results of the survey with the residents and/or the Resident Council President.</p> <p>3.1-3(b)(1)</p>		<p>binder and ensure that it contains the most recent survey report. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure the dignity of each resident was honored, related to staff entering the residents' rooms without waiting for permission to enter for 2 of 3 residents reviewed for dignity of the 4 residents who met the criteria for dignity. (Residents #17 and #33)</p> <p>Findings include:</p> <p>1. Resident #17 was interviewed on 4/23/13 at 10:04 a.m. The door to the resident's room was closed to maintain privacy during the interview.</p> <p>During the interview, Speech Therapist #1 knocked on the door and did not wait for permission to enter. She entered the resident's room, looked in the room, excused herself and left.</p> <p>A short time later, while the resident was still being interviewed, the Business Office Manager knocked on the resident's door. She did not wait</p>	F000241	<p>F241</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were adversely affected due to the deficient practice.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: No residents were adversely affected due to the deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Facility staff will be in-serviced by Director of Nursing and /or Staff Development Coordinator on the importance of waiting for permission to enter a resident's room after knocking by 5/24/13.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/Staff Development Coordinator will observe 10 staff members on a weekly basis to ensure residents' dignity is maintained. Audit will randomly take place on all shifts seven days a</p>	05/30/2013

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	<p>for permission to come into the room. She entered the room before the resident gave permission.</p> <p>2. On 4/22/13 at 3:00 p.m., Resident #33 was being interviewed. The door to the resident's room was closed.</p> <p>During the resident interview, CNA #2 knocked on the resident's room door. She entered the room without waiting for the resident to invite her in. She entered the room to search for some paper she had misplaced. The resident did not give permission for the CNA to enter the room.</p> <p>Interview with the Director of Nursing on 4/29/13 at 11:45 a.m., indicated all staff were to knock on the residents' doors. She also indicated the staff were to wait for permission to enter the resident's room.</p> <p>3.1-3(t)</p>		<p>week to ensure residents' dignity is protected. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident's choice was honored, related to the preferred time to get up in the morning for 1 of 3 residents reviewed for choices of the 7 residents who met the criteria for choices. (Resident #17)</p> <p>Findings include:</p> <p>Resident #17 was interviewed on 4/23/13 at 10:01 a.m. She indicated at times the staff will wake her up when she prefers to stay in bed.</p> <p>The record for Resident #17 was reviewed on 4/29/13 at 10:15 a.m. The admission MDS (Minimum Data Set) assessment dated 2/8/13, was reviewed. It indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated she was cognitively intact.</p> <p>The care plan for "Get Up Choices"</p>	F000242	<p>F 242</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #17 plan of care and care directive have been amended to reflect the resident's desire to remain in bed later in the morning.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: A facility audit will be completed by Nursing Administration by 5/24/13 to compare the care plan related to residents' choices with the directives placed on the residents' care guide to ensure choices are being honored.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Nursing staff will be in-serviced by DON/designee on the importance of honoring resident's choices of time to get up for the day 5/24/13.</p> <p>4. To ensure the deficient practice does not reoccur, the</p>	05/30/2013			

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	<p>dated 3/3/13, was reviewed. It indicated: "Per interview, wishes to have input in decision making regarding what time I get up for the day. -I will be satisfied with the time I get up as well as what I want to wear for the day. -Allow me to have input when to get up in the morning as often as I can. -If I am gotten up after breakfast please give me a choice of eating in my room at regular breakfast time or if breakfast is over please offer me alternate choices for food such as cereal. -Staff will assist me in dressing and oral care no matter what time I decide to get up."</p> <p>Interview with the MDS Coordinator on 4/29/13 at 10:48 a.m., indicated the care plan was initiated after an interview with the resident was completed to ascertain the resident's choices.</p> <p>She indicated the information regarding the resident's choices was to be placed on the Care Directive form that was used by the CNA's. Review of the Care Directive form dated 4/24/13, indicated there was no information related to the resident's desire to choose when to get up in</p>		<p>monitoring system established is: MDS Coordinator will audit 100% of both care plans and care directives of all new admissions and readmissions to ensure choices are clearly documented. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>the morning.</p> <p>Interview with the MDS Coordinator on 4/29/13 at 10:48 a.m., indicated the information that the resident wanted to choose what time to get up in the morning was not placed on the care directive. She indicated it should have been placed on the Care Directive sheet.</p> <p>The grievance logs were reviewed. There was a grievance form dated 4/18/13, that indicated, "see attached. " The attachment indicated, "Per conversation with (Resident #17's name): At about 5:45 a.m. on 4/18/13, a CNA came into my room. She was wearing gold boots and I don't remember her taking care of me before. She insisted it was time for me to get up, I did not want to get up, and started to initially, but then I told her I did not want to get up until 6:30 a.m. She insisted I get up . . ."</p> <p>Another form dated 4/23/13, indicated "Spoke with (CNA #3's name) regarding care of (Resident #17's name) on 4/18/13. Per (CNA #3's name), (Resident #17's name) is on the get-up list, (the list of residents who are assisted out of bed by the CNA's working on the midnight shift. The CNA's working the midnight shift</p>						

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	<p>leave the facility at 6:30 a.m.) . . ."</p> <p>Interview with the Staff Development Nurse on 4/29/13 at 11:36 a.m., indicated she interviewed the resident and she did note the concern. She indicated the resident's name was on the list that indicated she was to get up early by the midnight shift.</p> <p>Interview with the Director of Nursing on 4/29/13 at 11:45 a.m., indicated the resident's name should have been removed from the early get up list as soon as she indicated she preferred to choose when to get up in the morning. She indicated the residents can choose when to get up in the morning.</p> <p>3.1-3(u)(1)</p>				

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F000247 SS=B	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure 2 of 3 residents reviewed for admission, transfer and discharge, were notified of roommate changes prior to the change occurring. (Residents #103 and #47)</p> <p>Findings include:</p> <p>1. Interview with Resident #103 on 4/22/13 at 8:58 a.m., indicated the resident was not notified he would be receiving a new roommate prior to the roommate's arrival.</p> <p>The record for Resident #103 was reviewed on 4/30/13 at 5:20 p.m. Review of the Social Service Progress notes, indicated the resident had not been notified that he was receiving a new roommate.</p> <p>Interview with the Social Service Director on 4/30/13 at 5:50 p.m., indicated that if it was not documented in the Social Service progress notes, the resident must not have been notified.</p>	F000247	<p>F247</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #103 and Resident #47 both state that they were not adversely affected by the deficient practice.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: No other residents were adversely affected by the deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Social Service Director will be in-serviced by the Executive Director on 5/17/13 regarding procedure for documenting notification of roommate changes prior to change occurring.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: Admission director will audit 100% of new/readmissions or room changes to verify Social Service documentation of change in roommate has occurred prior to change occurring. The audits will be discussed during our monthly Performance Improvement</p>	05/30/2013			

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	<p>2. Interview with Resident #47 on 4/23/13 at 11:06 a.m., indicated that she had not been notified that she was receiving a new roommate.</p> <p>The record for Resident #47 was reviewed on 4/30/13 at 5:20 p.m. Review of the Social Service progress notes, indicated the resident was not notified that she was receiving a new roommate.</p> <p>Interview with the Social Service Director on 4/30/13 at 5:50 p.m., indicated that if it was not documented in the Social Service progress notes, the resident must not have been notified.</p> <p>3.1-3(v)(2)</p>		<p>Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an activity program was implemented for 1 of 1 residents reviewed for activities of the 1 resident who met the criteria for activities. (Resident #8)</p> <p>Findings include:</p> <p>Observations on 4/22, 4/23, 4/24, 4/25, 4/29 and 4/30/2013, indicated Resident #8 was not observed actively or passively participating in activities. The resident was observed sitting in a reclining wheelchair near the Nurses' station.</p> <p>Interview with Resident #8's daughter on 4/23/13 at 11:50 a.m., indicated staff no longer encouraged the resident to participate in activities since his return from the hospital and subsequent physical decline.</p> <p>Interview with the Activity Director (AD) on 4/29/13 at 12:05 p.m.,</p>	F000248	<p>F248</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: Resident #8 has a care plan in place for participation in facility activity programs. The corrective action for those residents having the potential to be affected by the same deficient practice is: A full facility audit will be conducted to insure that dependent residents are provided with activity choices designed to meet their interest and cognitive and functional capabilities. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Activity staff will be in-serviced by 5/24/13 by the Executive Director on assessment of resident preferences and capabilities to insure dependent residents preferences for activity programs are being met. To ensure the deficient practice does not reoccur, the monitoring system established is: Activity Director will audit activity logs for all dependent residents on a 	05/30/2013			

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	<p>indicated the resident was on the Geri-Club program as he was not able to participate in group activities. She explained the Geri-Club consisted of 2-5 residents at a time. The AD was not able to explain the lack of participation for the resident during the past month, but indicated she would look into it. The AD indicated the resident was more "zonked" recently and that may be partially why he was not participating.</p> <p>Further interview with the AD on 4/30/13 at 11:55 a.m., indicated the resident was not on a one-on-one activity program.</p> <p>The record for Resident #8 was reviewed on 4/25/13 at 10:30 a.m. The plan of care dated 11/06/12, indicated in the Behavior Monitoring book, "I may display anxious behaviors at times related to dx (diagnosis) of anxiety and dementia/confusion". Approaches included, but were not limited to, "Encourage me to attend activities of my choice to promote stimulation". Further problem identified, "I respond best to small group interaction because of my cognitive and functional status". Approaches included, but were not limited to, "Provide small group activities of</p>		<p>weekly basis to insure participation is evident. A residents plan of care will be amended to honor new preferences or in the event of a change of status. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>interest daily".</p> <p>The activity care plan initiated on 3/25/13, indicated the problem of "I respond best to small group interaction, because of my cognitive and functional status". Goal was "I will accept staff's assistance to participate in active games and current events 2 times weekly for 90 days". Approaches included, but were not limited to, "Provide small group activities of interest daily", and "Read sporting news to me during current events because I am a baseball fan and love the Cubs".</p> <p>Review of the Activity log for the month of April 2013, indicated the resident attended the Geri Club on 4/10 and 4/22/13. No other activities were documented for the month of April 2013.</p> <p>3.1-33(a)</p>				

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F000278 SS=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed related to urinary incontinence, pressure ulcers, and psychoactive medications for 4 of 29 residents reviewed for accurate MDS</p>	F000278	<p>F278</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Corrected MDS assessments for Residents #44, #73, #74 and #100 have been transmitted and accepted.</p> <p>2. The corrective action for those</p>	05/30/2013	

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	<p>assessments. (Residents #44, #73, #74, and #100)</p> <p>Findings include:</p> <p>1. The record for Resident #100 was reviewed on 4/25/13 at 11:59 a.m. The resident's diagnoses included, but were not limited to, dementia and altered mental status.</p> <p>The admission Minimum Data Set (MDS) assessment dated 12/7/12, indicated the resident was frequently incontinent of urine. The quarterly MDS assessment dated 3/9/13, indicated the resident was always incontinent of urine.</p> <p>Review of the Bladder Monthly Flow Report for the month of December 2012, indicated the resident was always incontinent of urine during his assessment reference period.</p> <p>Interview with the MDS Coordinator on 4/29/13 at 12:05 p.m., indicated the resident's admission MDS assessment was coded inaccurately. She indicated the resident should have been coded as "always incontinent" of urine.</p> <p>2. The record for Resident #74 was reviewed on 4/29/13 at 9:18 a.m. The</p>		<p>residents having the potential to be affected by the same deficient practice is: A random audit will be completed by 5/24/13 by Nursing Administration for MDSs which were completed during the last 30 days to insure accuracy. Any concerns were brought to the attention of the MDS coordinator for timely correction.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Staff members responsible for completing the MDS will be in-serviced on the steps needed to be taken to assure accuracy by 05/24/2013 by ADON/ designee.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: 30% of OBRA assessments will be audited weekly by the ADON/ designee prior to transmission to evaluate compliance with assessment accuracy. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>resident's admission Minimum Data Set (MDS) assessment dated 11/30/12, indicated the resident was frequently incontinent of urine. The resident's quarterly MDS assessment dated 2/23/13, indicated the resident was always incontinent of urine.</p> <p>Review of the Bladder Monthly Flow Report for the month of February 2013, indicated the resident had two episodes of being continent of urine during the assessment reference period.</p> <p>Interview with the MDS Coordinator on 4/29/13 at 12:13 p.m., indicated the resident's quarterly MDS assessment was coded inaccurately. She indicated the MDS assessment should have been coded "frequently incontinent" of urine due to he had 2 continent episodes during the assessment reference period.</p> <p>3. The record for Resident #73 was reviewed on 4/24/13 at 2:55 p.m. The resident had diagnoses that included, but were not limited to, diabetes, dementia and hypothyroidism.</p> <p>The quarterly MDS (Minimum Data Set) assessment dated 1/30/13,</p>				

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	<p>indicated the resident received antipsychotic medications for 7 of the past 7 days.</p> <p>Review of the January 2013 Physician Order Sheet, indicated there was no physician order for an antipsychotic medication.</p> <p>Review of the the January 2013 Medication Administration Record, indicated the resident did not receive antipsychotic medications during the month of January 2013.</p> <p>Interview with the MDS Coordinator on 4/25/13 at 11:35 a.m., indicted the MDS was inaccurately coded for the use of antipsychotic medications.</p> <p>4. The record for Resident #44 was reviewed on 4/24/13 at 10:20 a.m. The Minimum Data Set (MDS) assessment dated 1/17/13, indicated the resident's skin was intact and no open areas were noted.</p> <p>Resident #44 was hospitalized from 12/26/12 to 1/3/13. A physician order dated 1/4/13, for a left buttock wound indicated, "Cleanse area with normal saline and pat dry, apply hydrocolloid/duoderm (type of</p>						

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	<p>dressings) every 3 days and prn (as needed)".</p> <p>A Weekly Care Management review dated 1/16/13 to 1/22/13, indicated the resident was readmitted from a hospital stay with a Stage 2 pressure ulcer on the left buttock.</p> <p>Interview with the MDS Coordinator on 4/25/13 at 10:05 a.m., indicated the MDS assessment related to skin condition on 1/17/13 was incorrect.</p> <p>3.1-31(g)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure the care plan was reflective of the resident's current status related to incontinence for 1 of 3 residents reviewed for urinary incontinence of the 4 residents who met the criteria for urinary incontinence. (Resident # 32)</p> <p>Findings include:</p> <p>The record for Resident #32 was reviewed on 4/24/13 at 8:40 a.m. A Urinary Incontinence Assessment dated 2/24/13, indicated the resident had stress incontinence. The</p>	F000280	<p>F280</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: Resident #32 care plan and care directive has been updated. The corrective action for those residents having the potential to be affected by the same deficient practice is: A full facility audit will be completed by 5/24/13 by the Director of Nursing /designee to insure the care plans are reflective of the residents current status related to incontinence. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Nursing staff will be 	05/30/2013	

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	<p>assessment for Bowel and Bladder Training dated 2/24/13, indicated the resident had a score of 12; scores 7-14 indicated "candidate for toileting, timed or scheduled voiding".</p> <p>An Incontinence care plan dated 2/24/13, indicated a goal of, "Resident will alert staff of need to void between scheduled toileting times by verbal statement or non-verbal cues through next review date". Approaches included, but were not limited to, "Provide prompt pericare prn (as needed) for incontinent episodes between regularly scheduled toileting times".</p> <p>The Minimum Data Set (MDS) assessment dated 4/1/13, indicated the resident was not on a toileting program and further indicated he was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding).</p> <p>A Care Directive dated 4/23/13 was provided by LPN #6 on 4/24/13 at 9:05 a.m. The Care Directive indicated the resident was on the "check and change" program for urinary incontinence.</p> <p>Interview with CNA #4 on 4/24/13 at</p>		<p>in-serviced by 5/24/13 on the importance of insuring that the care plans are reflective of the resident's current status.</p> <p>4. To ensure the deficient practice does not reoccur the monitoring system established is: MDS coordinator will audit 100% of the OBRA MDSs weekly to ensure that the care plan and MDS reflect the residents current status related to incontinence. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>8:52 a.m., indicated the resident was always incontinent and was not on a scheduled toileting program.</p> <p>Interview with the Director of Nursing (DON) and MDS coordinator on 4/25/13 at 10:10 a.m., indicated the resident was on the "check and change" program and was always incontinent of urine. The DON indicated the care plan was incorrect.</p> <p>3.1-3(o)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written related to ensuring fall prevention measures were in use for 2 of 3 residents reviewed for accidents of the 5 who met the criteria for accidents. The facility also failed to ensure insulin was administered as ordered and behaviors were monitored for 2 of 10 residents reviewed for unnecessary medications. (Residents #1, #8, #47, and #100)</p> <p>Findings include:</p> <p>1. The record for Resident #100 was reviewed on 4/25/13 at 11:59 a.m. The resident's diagnoses included, but were not limited to, dementia and altered mental status.</p> <p>An entry in the Nursing progress notes dated 4/15/13 at 11:26 a.m., indicated the resident was discovered on the floor in his room on top of the floor mat in the fetal position. The resident was laying on his right side</p>	F000282	F 282 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #100 and resident #8 both had bed alarms in place during the entire survey. Resident # 1 had Lexapro discontinued on 5/10/13 and as of 5/15/13 has not exhibited any signs of depression. Care plan has been updated to reflect the change in status. Resident 47 has been seen by the physician and scheduled dose of insulin has been changed. The resident had no negative outcomes as a result of the documentation issue.2. The corrective action for those residents having the potential to be affected by the same deficient practice: A facility wide audit will be completed by 5/24/13 by the DON of all residents with orders for alarms to ensure they were in place. A facility wide audit will be completed by 5/24/13 by the DON on antidepressants to verify plan of care accurately reflex's resident's status. A facility wide audit will be completed by 5/24/13 by the DON completed on insulin administration documentation and any issues noted were addressed.3. The measures put	05/30/2013	

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	<p>with his eyes open and facing the window.</p> <p>Review of the Incident follow up and Recommendation form, indicated the Nurse was called to the room and found the resident on the floor, on top of the mat on his right side. Review of the statement from the Staff Development Coordinator, indicated when she entered the resident's room during Manager rounds, the resident was laying on the mat on his right side. He was on a large positioning pillow facing the window. "Called Nurse to room for assistance. No obvious injury. Bed low, but not in lowest position."</p> <p>The plan of care dated 12/5/12 and updated on 4/15/13, indicated the resident was at risk for fall related injury as evidenced by fall risk factors present as determined by the fall risk screen. The interventions indicated the resident was to have a low bed with bilateral floor mats and a bed alarm.</p> <p>Interview with the Staff Development Coordinator on 4/30/13 at 12:20 p.m., indicated that she was the one who found the resident on the floor. She indicated it appeared the resident had slid out of the bed. She indicated if</p>		<p>into place and a systemic change made to ensure the deficient practice does not reoccur: Social Service Director and MDS coordinator were in-serviced on 5/15/13 by the DON on proper documentation on care plans. Nursing Staff will be in-serviced by 5/24/13 by the DON/Designee on following care plan intervention and proper insulin documentation.4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit daily 25% of the insulin administration sheets to verify correct documentation Monday through Friday, weekend issues will be reviewed on Monday. Social Service will audit weekly 25% of the behavior care plans to verify correct documentation. Department heads will audit fall prevention devices on 25% of the residents with devices randomly 3 times a week on all shifts including weekends. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>the resident's bed alarm had been sounding, she would have documented that in her statement.</p> <p>Interview with the Director of Nursing on 4/30/13 at 12:30 p.m., indicated the resident's bed alarm should have been in use.</p> <p>2. The record for Resident #1 was reviewed on 4/24/13 at 9:14 a.m. The resident's diagnosis included, but was not limited to, depression.</p> <p>Review of the April 2013 Physician's order summary (POS), indicated the resident received 5 milligrams (mg) of Lexapro (an antidepressant) daily.</p> <p>The plan of care dated 6/26/12 and reviewed on 4/9/13, indicated the resident was at risk for discomfort and side effects related to the use of a psychotropic medication for depression. One of the interventions indicated the resident's behavior was to be monitored every shift and documented.</p> <p>Review of the Behavior monitoring book, indicated there was no behavior/intervention sheet for the resident.</p> <p>Interview with the Social Service</p>				

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	<p>Director on 4/24/13 at 11:45 a.m., indicated the resident would not have a behavior/intervention flow sheet in the Behavior monitoring book because he was on an antidepressant. When asked how the resident's behaviors were being monitored every shift per his care plan, the Social Service Director was not aware.</p> <p>Interview with the Director of Nursing on 4/29/13 at 9:00 a.m., indicated the resident would not have had a behavior/intervention flow sheet due to he was receiving an antidepressant. She also indicated the resident's care plan should be revised related to monitoring behaviors.</p> <p>3. The record for Resident #47 was reviewed on 4/24/13 at 10:55 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's order dated 9/7/12, and listed on the April 2013 Physician's order summary (POS), indicated the resident was to receive insulin based on the following sliding scale:</p> <p>Novolin R sliding scale 0-150=0 151-200=4 units</p>				

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	<p>201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units Call MD if BS below 80 or above 400</p> <p>Review of the March 2013 Medication Administration Record (MAR), indicated the resident's blood sugar on 3/3/13 at 6:00 a.m. was 219. The resident received 4 units of insulin rather than 8 units. At 4:00 p.m., the resident's blood sugar was 263, there was no documentation of insulin administration. On 3/21/13 at 6:00 a.m., the resident's blood sugar was 182, there was no documentation of insulin administration. On 3/23/13 at 8:00 p.m., the resident's blood sugar was 360, documentation indicated the resident received insulin in her left abdomen, however, there was no documentation to indicate how much insulin the resident received.</p> <p>Review of the plan of care dated 9/6/12, which was reviewed on 3/12/13, indicated the resident was at risk for complications associated with hyper or hypoglycemia (high and low blood sugar) related to insulin dependent diabetes mellitus. One of the interventions indicated the resident's insulin was to be administered as ordered.</p>				

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	<p>Interview with the Director of Nursing on 4/30/13 at 2:30 p.m., indicated the resident had received the wrong dose of insulin on 3/3/13 and there was no documentation located anywhere else to indicate how much insulin the resident had received on 3/3 at 4:00 p.m., 3/21 and 3/23/13.</p> <p>4. Observations on 4/22, 4/23, 4/24, 4/25, 4/29 and 4/30/2013, indicated Resident #8 was not observed actively or passively participating in activities. The resident was observed sitting in a reclining wheelchair near the Nurses' station.</p> <p>Interview with Resident #8's daughter on 4/23/13 at 11:50 a.m., indicated staff no longer encouraged the resident to participate in activities since his return from the hospital and subsequent physical decline.</p> <p>Interview with the Activity Director (AD) on 4/29/13 at 12:05 p.m., indicated the resident was on the Geri-Club program as he was not able</p>						

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	<p>to participate in group activities. She explained the Geri-Club consisted of 2-5 residents at a time. The AD was not able to explain the lack of participation for the resident during the past month, but indicated she would look into it. The AD indicated the resident was more "zonked" recently and that may be partially why he was not participating.</p> <p>Further interview with the AD on 4/30/13 at 11:55 a.m., indicated the resident was not on a one-on-one activity program.</p> <p>The record for Resident #8 was reviewed on 4/25/13 at 10:30 a.m. The plan of care dated 11/06/12, indicated in the Behavior Monitoring book, "I may display anxious behaviors at times related to dx (diagnosis) of anxiety and dementia/confusion". Approaches included, but were not limited to, "Encourage me to attend activities of my choice to promote stimulation". Further problem identified, "I respond best to small group interaction because of my cognitive and functional status". Approaches included, but were not limited to, "Provide small group activities of interest daily".</p>			

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	<p>The activity care plan initiated on 3/25/13, indicated the problem of "I respond best to small group interaction, because of my cognitive and functional status". Goal was "I will accept staff's assistance to participate in active games and current events 2 times weekly for 90 days". Approaches included, but were not limited to, "Provide small group activities of interest daily", and "Read sporting news to me during current events because I am a baseball fan and love the Cubs".</p> <p>Review of the Activity log for the month of April 2013, indicated the resident attended the Geri Club on 4/10 and 4/22/13. No other activities were documented for the month of April 2013.</p> <p>Further record review for Resident #8 was completed on 4/29/13 at 9:55 a.m. Nursing progress notes indicated the resident was found on the floor in his room on 4 occasions (3/28/13, 4/4/13, 4/14/13 and 4/22/13) since his re-admission to the facility on 3/19/13.</p> <p>A Falls care plan initiated on 3/19/13, indicated the problem of, "At risk for fall related injury as evidenced by previous fall related to impaired</p>						

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	<p>cognition-medication usage antidepressant, lithium, antianxiety, antihypertensive". Approaches included, but were not limited to, "Provide environmental adaptations-low platform bed-bed and chair alarm-mat beside bed-do not leave him unoccupied in the wheelchair in his room, put it in the hallway".</p> <p>A Witness Interview Form (WIF) dated 3/28/13, indicated the resident was found at 11:00 p.m. "I was passing out water for the residents, the first door I went to was 110. As I opened the door I saw [resident's name] sitting on the floor mat". Second WIF indicated resident was "...sitting upright on the mat on the side of his bed". No bed alarm was noted on the WIF's.</p> <p>A WIF dated 4/4/13 at 3:45 p.m., indicated, "I walked down to South unit to bring [resident's name] to therapy. As I was approaching his room observed a CNA open his door, look inside, then close the door again and walk away. I entered the room a few seconds later to find [resident's name] sitting on the fall mat next to his bed with his back and head resting against his bed. I noticed he wasn't wearing any pants or shoes,</p>				

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	<p>just a sweatshirt, brief, and Ted hose. I retrieved his wheelchair from across the room, asked him if he was okay and proceeded to get help. I did not hear the bed alarm going off at any time".</p> <p>Interview with Physical therapist #1 on 4/30/13 at 1:10 p.m., indicated that she confirmed the written statement and indicated an incident report had been made at that time.</p> <p>A WIF dated 4/14/13 at 1:40 p.m., indicated the resident was observed slipping out of bed onto the floor mat. A second WIF indicated the witness was called to the room by first witness and resident was observed on floor mat next to bed sitting in upright position. No bed alarms were noted.</p> <p>A Nursing progress note dated 4/22/13 at 7:50 a.m., indicated the bed alarm was sounding and the resident was found lying on floor mat next to bed.</p> <p>During an Interview with the Director of Nursing (DON) on 4/30/13 at 3:07 p.m., the DON was asked to provide documentation that bed alarms were in use prior to the incidents on 3/28/13, 4/4/13 and 4/14/13. She reviewed the fall reports and was</p>				

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	unable to provide documentation of bed alarms in use for these incidents. 3.1-35(g)(2)				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure an assessment was completed, related to bruising for 1 of 3 residents reviewed for non-pressure skin conditions of the 6 residents who met the criteria for Non-pressure skin conditions. (Resident #3)</p> <p>Findings include:</p> <p>Resident #3 was observed on 4/23/13 at 10:57 a.m. The resident had a bruise on the left hand that was blue in color and 2 inches in diameter.</p> <p>On 4/24/13 at 9:53 a.m., the resident was observed. The bruise on her left hand was noted to be blue/green in color and 2 inches in diameter. The bruise was located near her left thumb.</p> <p>On 4/26/13 at 12:20 p.m., the resident was in the beauty shop. There was a bluish/green bruise noted on her left hand, 2 inches in</p>	F000309	F 309 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #3 was not negatively affected by the bruise on her hand. The resident's physician and family were made aware and documentation completed in accordance with facility policy. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: A full facility audit of skin assessments of the residents was completed by the Wound Care Nurse on 5/15/13 and any issues identified were immediately addressed. 3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Nursing Staff will be in-serviced by the DON/designee by 5/24/13 on proper assessment and documentation on the weekly skin integrity data collection form. 4. To ensure the deficient practice does not reoccur, the monitoring system established is:	05/30/2013			

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	<p>diameter. It was near her thumb. Interview with the Director of Nursing at that time, indicated the resident had a bruise on the left hand.</p> <p>The record for Resident #3 was reviewed on 4/24/13 at 10:05 a.m. The resident had diagnoses that included, but were not limited to, dementia, depression, anemia and anxiety.</p> <p>Review of the Weekly Skin Integrity Data Collection form, indicated the resident's skin assessments were completed on 4/22/13 and on 4/25/13. Both of the assessments indicated the resident's skin was intact and had no bruises.</p> <p>Interview with the Director of Nursing on 4/26/13 at 12:17 p.m., indicated the licensed nurse was to assess the resident during showers and document on the Weekly Skin Integrity Data Collection form. She indicated bruises were to be identified and documented. She indicated the Weekly Skin Integrity Data Collection form for Resident #3 was completed on 4/22/13 and on 4/25/13. She indicated no bruise was identified or assessed on those dates. She indicated the bruise on the resident's left hand should have been identified,</p>		<p>Wound Care Nurse will audit the Weekly Skin Integrity forms comparing the completed form to the current skin status of the resident. Wound Care Nurse will audit two residents daily Monday – Friday. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>				

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	<p>assessed and documented on the Weekly Skin Integrity Data Collection sheet.</p> <p>The policy titled, "Post-admission Weekly Skin Assessments" that was undated, was provided by the Nurse Consultant on 4/25/13 at 9:45 a.m. She indicated the policy was current. The policy indicated: "-On a weekly basis, a licensed professional searches for areas of skin that differ from surrounding tissue. These areas may be painful, firm, boggy, soft warmer, or cooler in temperature compared to adjacent tissue, looking also for edema and induration (hardness). Particular attention is given to bony prominence. The results of the skin assessment are documented on the Weekly Skin Integrity Data Collection form. The weekly Pressure ulcer Status Record and the Non-pressure Skin Condition Record are used for weekly assessment of existing wounds."</p> <p>3.1-37(a)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided for a resident with a pressure sore related to not repositioning and keeping the resident dry for 1 of 3 residents reviewed for pressure sores of the 3 residents that met the criteria for pressure sores. (Resident #8)</p> <p>Findings include:</p> <p>On 4/25/13 from 10:35 a.m. to 11:55 a.m., Resident #8 was observed sitting in his wheelchair in the South unit hall near the Nurses' station. The resident was not repositioned during this time. At 12:52 p.m., the resident was transferred into bed. His incontinence brief was removed and it was saturated with urine. The resident's buttocks were discolored</p>	F000314	<p>F 314</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: Resident #8 has had two of his areas heal as of 5/1/13. At no time while residing in this facility has Resident # 8 ever had 14 open areas as was stated in the 2567. The affected areas were assessed as excoriation. The corrective action for those residents having the potential to be affected by the same deficient practice: No other residents were found to be affected by the deficient practice. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur. Nursing staff to be in-serviced by the DON/designee on repositioning and incontinence care of dependent residents by 5/24/13.. To ensure the deficient practice does not reoccur, the monitoring system established is: 	05/30/2013			

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	<p>red on both sides from the coccyx (top of crease area) to the scrotum. Four open areas were observed on the right buttock and 5 open areas on the left buttock. The scrotum was red with 5 round opened areas visible while the resident was positioned on his right side.</p> <p>On 4/29/13 from 12:15 p.m. to 3:30 p.m., the resident was observed in the South unit hall sleeping in his wheelchair with his head resting to the left. No position changes were made during this time.</p> <p>On 4/30/13 at 8:50 a.m., 9:40 a.m., 1:05 p.m., 2:05 p.m., 3:04 p.m., 4:10 p.m., and 4:40 p.m., the resident was observed in the South unit hall in his wheelchair. At 10:22 a.m. and 11:27 a.m., the resident was observed in his wheelchair in his room.</p> <p>The record for Resident #8 was reviewed on 4/25/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes, anxiety disorder, depression and bi-polar disorder. The resident was hospitalized in March and readmitted to the facility on 3/19/13. Pressure ulcers were noted upon his return to the buttocks, right ankle and excoriation was noted to his scrotum.</p>		<p>ADON/designee will audit 25% of the dependent residents for incontinence and repositioning randomly 3 times per week encompassing, all shifts. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>				

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	<p>The Pressure Ulcer Prevention Checklist dated 3/19/13, indicated the following interventions were ordered: "3. Elevate heels off bed surface...10. Initiate weekly skin integrity assessment check form...11. Physical/Occupational/Speech therapist consult...14 other intervention: Xenederm to buttock, Desitin to scrotum".</p> <p>The Pressure Ulcer care plan initiated on 3/19/13 indicated the problem of, "Resident has pressure ulcers-location right outer ankle Stage DTI (deep tissue injury) Location: buttock crease Stage 2 Location: Left buttock, Stage 3 Location: right buttock, Stage 2 relating to-Immobility-Incontinence". Approaches included, but were not limited to, "Assist PRN (as needed) to reposition/shift weight to relieve pressure", "Complete weekly skin check" and "Provide incontinence care after incontinence episodes; apply barrier cream PRN".</p> <p>The Pressure Ulcer Status Record dated 4/24/13 for the right buttock, indicated no measurement for stage 2 wound, "areas scattered through (sic) new tx (treatment)-open air Xenederm". Left buttock stage 2,</p>						

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	<p>measured 2.0 centimeters (cm) x 1.0 cm, open to air with Xenederm" and buttocks crease was stage 2, measured 0.1 cm x 0.1 cm.</p> <p>The Care Directive dated 4/23/13, indicated, "Must lay down after meals due to excoriation" and "Lay down after lunch and get up by 3:30 p.m."</p> <p>Interview with the Director of Nursing and LPN #2 on 4/25/13 at 1:30 p.m., indicated the wounds were greatly improved since the resident's return from the hospital on 3/19/13. When questioned about the lack of dressing, the LPN indicated the resident previously had orders for a dressing, but because of his incontinence status, the dressing was not effective as it was always wet, the current order was Xenederm and leave open to air. When questioned related to the open to air status as the resident was incontinent of urine and bowel and the brief was on the resident at all times, the LPN indicated the excoriation to the scrotum was related to wetness. The Director of Nursing indicated leaving wounds open to air while the resident was in bed was not currently practiced, but was not contraindicated by facility policy. The resident's air mattress remained off. When questioned if the resident was</p>			

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	<p>ever left on his side to relieve pressure, the Director of Nursing indicated he was able to turn himself onto his back which was his preferred position.</p> <p>Interview on 4/30/13 at 3:04 p.m., with CNA #2 regarding the resident's routine, indicated she toileted the resident every two hours by taking him to the bathroom. She indicated he was put into bed after lunch by day shift and she normally got him up around four o'clock. The resident was observed sitting in the hallway during the interview.</p> <p>3.1-40(a)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure fall prevention measures were in place for 2 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Residents #8 and #100)</p> <p>Findings include:</p> <p>1. The record for Resident #100 was reviewed on 4/25/13 at 11:59 a.m. The resident's diagnoses included, but were not limited to, dementia and altered mental status.</p> <p>An entry in the Nursing progress notes dated 4/15/13 at 11:26 a.m., indicated the resident was discovered on the floor in his room on top of the floor mat in the fetal position. The resident was laying on his right side with his eyes open and facing the window.</p> <p>Review of the Incident follow up and Recommendation form, indicated the Nurse was called to the room and</p>	F000323	<p>F323 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident # Resident #100 and resident #8 both had bed alarms in place during the entire survey. 2. The corrective action for those residents having the potential to be affected by the same deficient practice is: A facility audit was completed by Director of Nursing on 5/08/2013 of all residents with orders for alarms to ensure they were in place. 3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Nursing Staff will be in-serviced by 5/24/13 on following care plan interventions for fall prevention measures.4. To ensure the deficient practice does not reoccur, the monitoring system established is: Department heads will audit fall prevention devices using the care directives on 25% of the residents with devices randomly 3 times a week including all shifts weekends. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will</p>	05/30/2013			

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	<p>found the resident on the floor, on top of the mat on his right side. Review of the statement from the Staff Development Coordinator, indicated when she entered the resident's room during Manager rounds, the resident was laying on the mat on his right side. He was on a large positioning pillow facing the window. "Called Nurse to room for assistance. No obvious injury. Bed low, but not in lowest position."</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 3/9/13, indicated the resident had a fall since his prior assessment with no injury.</p> <p>The plan of care dated 12/5/12 and updated on 4/15/13, indicated the resident was at risk for fall related injury as evidenced by fall risk factors present as determined by the fall risk screen. The interventions indicated the resident was to have a low bed with bilateral floor mats and a bed alarm.</p> <p>The 4/10/13 Fall risk assessment indicated the resident scored a "12" which was a high risk for falls.</p> <p>Interview with the Staff Development Coordinator on 4/30/13 at 12:20 p.m., indicated that she was the one who</p>		determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.				

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	<p>found the resident on the floor. She indicated it appeared the resident had slid out of the bed. She indicated if the resident's bed alarm had been sounding, she would have documented that in her statement.</p> <p>Interview with the Director of Nursing on 4/30/13 at 12:30 p.m., indicated the resident's bed alarm should have been in use.</p> <p>2. The record for Resident #8 was on reviewed on 4/29/13 at 9:55 a.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes, anxiety disorder, depression and bi-polar disorder. Nursing progress notes indicated the resident was found on the floor in his room on 4 occasions (3/28/13, 4/4/13, 4/14/13</p>				

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	<p>and 4/22/13) since his re-admission to the facility on 3/19/13.</p> <p>A Falls care plan initiated on 3/19/13, indicated the problem of, "At risk for fall related injury as evidenced by previous fall related to impaired cognition-medication usage antidepressant, lithium, antianxiety, antihypertensive". Approaches included, but were not limited to, "Provide environmental adaptations-low platform bed-bed and chair alarm-mat beside bed-do not leave him unoccupied in the wheelchair in his room, put it in the hallway".</p> <p>A Witness Interview Form (WIF) dated 3/28/13, indicated the resident was found at 11:00 p.m. "I was passing out water for the residents, the first door I went to was 110. As I opened the door I saw [resident's name] sitting on the floor mat". Second WIF indicated resident was "...sitting upright on the mat on the side of his bed". No bed alarm was noted on the WIF's.</p> <p>A WIF dated 4/4/13 at 3:45 p.m., indicated, "I walked down to South unit to bring [resident's name] to therapy. As I was approaching his room observed a CNA open his door,</p>						

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	<p>look inside, then close the door again and walk away. I entered the room a few seconds later to find [resident's name] sitting on the fall mat next to his bed with his back and head resting against his bed. I noticed he wasn't wearing any pants or shoes, just a sweatshirt, brief, and Ted hose. I retrieved his wheelchair from across the room, asked him if he was okay and proceeded to get help. I did not hear the bed alarm going off at any time".</p> <p>Interview with Physical therapist #1 on 4/30/13 at 1:10 p.m., indicated that she confirmed the written statement and indicated an incident report had been made at that time.</p> <p>A WIF dated 4/14/13 at 1:40 p.m., indicated the resident was observed slipping out of bed onto the floor mat. A second WIF indicated the witness was called to the room by first witness and resident was observed on floor mat next to bed sitting in upright position. No bed alarms were noted.</p> <p>A Nursing progress note dated 4/22/13 at 7:50 a.m., indicated the bed alarm was sounding and the resident was found lying on floor mat next to bed.</p>						

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	<p>During an Interview with the Director of Nursing (DON) on 4/30/13 at 3:07 p.m., the DON was asked to provide documentation that bed alarms were in use prior to the incidents on 3/28/13, 4/4/13 and 4/14/13. She reviewed the fall reports and was unable to provide documentation of bed alarms in use for these incidents.</p> <p>3.1-45(a)(2)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure Registered Dietitian (RD) recommendations were carried out in a timely manner for 1 of 3 residents reviewed for nutrition of the 8 residents who met the criteria for nutrition. (Resident #87)</p> <p>Findings include:</p> <p>The record for Resident #87 was reviewed on 4/25/13 at 2:33 p.m. A progress noted completed by the Registered Dietitian (RD) on 4/3/13, indicated the resident was 98% of her ideal body weight (IBW), but has had an involuntary weight loss recently, though the amounts and time frame were unclear. Current oral intake met recommended dietary intakes on the lower end range. Need to obtain food preferences. Recommend evening snack with protein and 2 cal Med</p>	F000325	<p>F 325</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: During the survey an order was written by the evening shift supervisor for 2 cal Med Pass 2 ounces once a day for Resident # 87.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: An audit was completed on 5/03/2013 to review dietary recommendations for the last 30 days by the DON to verify that no other resident was affected by this deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: In-service will be provided to the ADON by the DON by 5/24/13 on facility policy and procedure for following up on dietary recommendations.</p> <p>4. To ensure the deficient practice does not reoccur, the</p>	05/30/2013			

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	<p>Pass 2 ounces once a day.</p> <p>A Physician's order dated 4/3/13, indicated the resident was to receive a 1/2 meat sandwich at bedtime daily. There was no order related to the 2 cal Med Pass.</p> <p>Interview with the Director of Nursing on 4/30/13 at 1:24 p.m., indicated the dietary recommendation related to the 2 cal Med Pass was missed. She also indicated RD recommendations should be turned around within 72 hours.</p> <p>3.1-46(a)(1)</p>		<p>monitoring system established is: DON/designee will audit weekly 100 % of the RD recommendations The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure insulin was administered as ordered as well as monitoring behaviors for antianxiety medications and monitoring lithium levels for 3 of 10 residents reviewed for unnecessary medications. (Residents #3, #8, and #47)</p> <p>Findings include:</p> <p>1. The record for Resident #47 was</p>	F000329	<p>F329</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #47 has been seen by the physician and scheduled dose of insulin has been changed. The resident had no negative outcomes as a result of the documentation issue. Resident # 3 had her Alprazolam .125 BID decreased to daily on 5/16/13 and will monitor for seven days and if there are no signs and symptoms of anxiety, facility will discuss discontinuing the</p>	05/30/2013			

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	<p>reviewed on 4/24/13 at 10:55 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's order dated 9/7/12, and listed on the April 2013 Physician's order summary (POS), indicated the resident was to receive insulin based on the following sliding scale:</p> <p>Novolin R sliding scale 0-150=0 151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units Call MD if BS below 80 or above 400</p> <p>Review of the March 2013 Medication Administration Record (MAR), indicated the resident's blood sugar on 3/3/13 at 6:00 a.m. was 219. The resident received 4 units of insulin rather than 8 units. At 4:00 p.m., the resident's blood sugar was 263, there was no documentation of insulin administration. On 3/21/13 at 6:00 a.m., the resident's blood sugar was 182, there was no documentation of insulin administration. On 3/23/13 at 8:00 p.m., the resident's blood sugar was 360, documentation indicated the resident received insulin in her left abdomen, however, there was no</p>		<p>Alprazolam and continue to monitor for signs and symptoms of anxiety. Resident # 8 physician was notified and orders received for Lithium level to be drawn on 4/30.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: A facility wide audit was completed on insulin administration documentation and any issues noted were addressed. A facility audit will be completed related to behavior monitoring of residents receiving anti- anxiety medication by the Social Service Director. No other residents residing in the facility are currently receiving Lithium.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Licensed nurses will be in-serviced by Director of Nursing/designee by 5/24/13 regarding proper insulin documentation and lithium level monitoring as indicated when medication in use. Facility staff will receive educational training by the DON/Staff Development Coordinator related to behavior monitoring and required documentation</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit daily 25% of the insulin administration sheets to verify correct documentation</p>		

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	<p>documentation to indicate how much insulin the resident received.</p> <p>Interview with the Director of Nursing on 4/30/13 at 2:30 p.m., indicated the resident had received the wrong dose of insulin on 3/3/13 and there was no documentation located anywhere else to indicate how much insulin the resident had received on 3/3 at 4:00 p.m., 3/21 and 3/23/13.</p> <p>2. Resident #3 was observed on 4/24/13 at 9:35 a.m., seated in her wheelchair. The resident was calm.</p> <p>The resident was observed on 4/24/13 at 1:38 p.m. She was in bed, her eyes were closed, she was calm.</p> <p>On 4/25/13 at 8:35 a.m., the resident was seated in her wheelchair in the dining room, staff sitting next to her. The resident was calm.</p> <p>On 4/26/13 at 12:20 p.m., the</p>		<p>Monday through Friday, weekend issues will be reviewed on Monday. Social Service will audit weekly 25% of the behavior monitoring sheets to verify correct documentation. Resident # 8 Lithium level will be drawn and results monitored monthly as ordered by the physician. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>resident was observed, seated in her wheelchair, in the beauty shop. She was calm.</p> <p>The record for Resident #3 was reviewed on 4/24/13 at 10:05 a.m. The resident had diagnoses that included, but were not limited to, dementia, depression, anemia and anxiety.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 3/22/13, was reviewed. It indicated the resident had long and short term memory problems. It also indicated the resident had exhibited no mood or behavior symptoms. It also indicated she received an antianxiety medication for 7 days in the past 7 days.</p> <p>The resident was admitted to the facility on 5/10/12. The resident had been receiving alprazolam (an antianxiety medication) for anxiety since admission.</p> <p>The Social Service progress note dated 1/11/13, indicated. "Behavior meeting held today-d/c (Discontinue) seroquel (an antipsychotic medication)." There was no evidence in the progress note that the resident had anxious behavior or that an</p>						

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	<p>antianxiety medication was used.</p> <p>Interview with the Social Service Director on 4/24/13 at 11:33 a.m., indicated she was not aware that the resident was receiving an antianxiety medication. She indicated there should be behavior intervention monitoring sheets for the residents receiving antianxiety medication.</p> <p>The Behavior Book was reviewed. There were no "Behavior Intervention Monthly Flow Records" for the resident for April 2013 in the behavior book. There was no evidence the staff was monitoring for signs of anxiety.</p> <p>Interview with the Director of Nursing on 4/25/13 at 10:18 a.m., indicated there should have been Behavior Intervention Monthly Flow Records to monitor the resident's anxiety and the continued need for the antianxiety medication.</p> <p>The "Hammond Whiting Behavior Management" policy dated 3/10/10 was provided by the Director of Nursing on 4/29/13. She indicated the policy was current. The policy indicated, "It is the policy of Hammond-Whiting Care Center to monitor the behaviors and/or</p>						

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	<p>psychotropic medications to ensure regulatory compliance.</p> <p>1. Residents could include but are not limited to, those that are receiving antipsychotic and anxiety medications, and those residents that are exhibiting behaviors that are harmful to themselves and others. A behavior intervention monthly flow record will be initiated to address the specific behavior. This form will only be completed when a behavior occurs and will be left blank when there is no behavior."</p> <p>3. The record for Resident #8 was reviewed on 4/25/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder, depression and bi-polar disorder. Review of the April 2013 Physician's order summary (POS), indicated the resident received lithium daily for bi-polar diagnosis.</p> <p>Review of the Nursing Spectrum 2010 Drug Handbook, indicated lithium had a boxed warning, "Lithium toxicity is closely related to lithium blood level and can occur at doses close to therapeutic levels. Before starting therapy, ensure that resources for prompt, accurate blood lithium testing</p>						

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	<p>are available."</p> <p>A Behavioral Monitoring care plan dated 8/20/11, indicated the problem of, "Potential for discomfort and side effects related to the use of psychotropic medications for the diagnosis of anxiety, depression and bipolar". Approaches included, but were not limited to, "lithium level monthly".</p> <p>The lithium levels for March 2013 and April 2013 were not located in the resident's record.</p> <p>Interview with the Director of Nursing on 4/30/13 at 2:45 p.m., indicated the lithium levels had not been done for March or April. She further indicated she had notified the physician and obtained an order for a stat lithium blood test.</p> <p>3.1-48(a)(3)</p>						

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F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 3 of 13 residents observed during medication pass. Four errors were observed during 26 opportunities for error during medication administration. This resulted in a medication error rate of 15%. (Residents #11, #55, and #87)</p> <p>Findings include:</p> <p>1. On 4/25/13 at 10:03 a.m., LPN #3 was observed preparing medications for Resident #11. The resident received Glipizide (a medication to treat diabetes) 5 milligrams (mg) by mouth and Protonix (a medication used to treat acid reflux) 40 mg by mouth.</p> <p>The record for Resident #11 was reviewed on 4/30/13 at 9:30 a.m. The April 2013 Physician's order summary (POS), indicated the resident was to receive Glipizide 5 mg by mouth twice a day before meals at 8:00 a.m. and 5:00 p.m. and Protonix 40 mg by</p>	F000332	<p>F 332</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident # 11 now receives the Glipizide before meals at 8:00 AM and 5:00 PM, the administration time for the Protonix has been changed to 6:00 AM. Resident # 55 order for Peridex has been discontinued by the physician as of 4/30/13, and Resident # 87 was not adversely affected by the deficient practice.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: A facility wide audit was completed on insulin administration documentation and any issues noted were addressed. No other resident is currently receiving Peridex. No other facility residents receiving meds before meals have been adversely affected by the deficient practice.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: Licensed Nurses will be in-serviced by DON/Designee by 5/24/13 on adherence to special instructions during medication pass and on proper administration of an</p>	05/30/2013			

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	<p>mouth twice a day before meals at 8:00 a.m. and 5:00 p.m.</p> <p>Interview with the Director of Nursing on 4/30/13 at 11:00 a.m., indicated the resident should have received both medications before breakfast rather than after.</p> <p>2. On 4/25/13 at 10:59 a.m., LPN #4 checked Resident #87's blood sugar. The resident's blood sugar was 327. The LPN indicated the resident would receive insulin based on her blood sugar. At 11:05 a.m., LPN #4 was observed preparing a Novolog insulin injection for the resident. The LPN indicated the resident was to receive 2 units of insulin. The LPN proceeded back to the resident's room and administered the injection.</p> <p>The record for Resident #87 was reviewed on 4/25/13 at 11:10 a.m. Review of the April 2013 Physician's order summary (POS), indicated the resident was to receive 4 units of Novolog insulin for a blood sugar of 301-349. The LPN indicated she thought the resident's blood sugar was 227. When the memory of the glucometer was checked, it indicated the resident's blood sugar was 327. The LPN indicated that she needed to give the resident 2 more units of</p>		<p>oral rinse.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit daily 25% of the insulin administration sheets to verify correct documentation Monday through Friday, weekend issues will be reviewed on Monday. DON/designee will audit Nursing management will audit one nurse weekly to ensure special instructions surrounding certain medications are followed. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>				

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	<p>insulin.</p> <p>3. On 4/26/13 at 8:57 a.m., LPN #5 was observed preparing medications for Resident #55. The LPN poured 15 milliliters (mls) of Peridex (an oral rinse) into a medication cup and proceeded to the resident's room. The LPN wet a wash cloth and poured some of the Peridex onto it. She then proceeded to wipe the resident's lips. After wiping the resident's lips, she then placed the wash cloth in the resident's mouth to clean the roof of the resident's mouth. The LPN then proceeded to pour some of the liquid into the resident's mouth. The resident was instructed to gargle and spit, however, the resident started to cough and ended up swallowing the liquid.</p> <p>The record for Resident #55 was reviewed on 4/30/13 at 9:30 a.m. Review of the April 2013 Physician's order summary (POS), indicated the resident was to receive Chlorhexidine gluconate (Peridex) 0.12%, rinse mouth with 15 ml's by mouth twice a day after brushing teeth.</p> <p>Review of the manufacturer's recommendations on 4/30/13 at 9:45 a.m., indicated the medication was not to be swallowed.</p>				

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	<p>Interview with the Director of Nursing on 4/30/13 at 11:00 a.m., indicated the resident's mouth should have been cleansed with a Peridex soaked mouth swab. She also indicated the order needed to be clarified due to the resident's inability to properly rinse her mouth out.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and record review, the facility failed to ensure medications were disposed of properly for 1 of 6 residents reviewed for medication administration. (Resident #11)</p> <p>Findings include:</p> <p>On 4/25/13 at 10:09 a.m., LPN #3 was observed preparing medications for Resident #11. A Glipizide (a medication used to treat diabetes) tablet fell on top of the Medication Cart. At this time, the LPN disposed of the tablet in the trash can located</p>	F000425	<p>F 425</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: There were no residents affected by the deficient practice. The corrective action for those residents having the potential to be affected by the same deficient practice: There were no residents affected by the deficient practices. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: In-service will be provided to the licensed nurses by the DON 5/24/13 on facility policy and procedure for disposing of 	05/30/2013			

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	<p>on the side of the Medication Cart.</p> <p>Review of the Medication Destruction policy provided by the Director of Nursing on 4/30/13 at 9:30 a.m., and identified as current, indicated "tablets, capsules, and liquids are washed down the toilet/sink or disposed of in another acceptable manner. Medication destruction occurs only in the presence of two licensed nurses or one licensed nurse and a pharmacist."</p> <p>Interview with the Director of Nursing on 4/30/13 at 11:30 a.m., indicated that when a pill was dropped on the medication cart, the nurse should get a second witness for medication destruction.</p> <p>3.1-25(o)</p>		<p>medications properly.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: Staff Development Coordinator/designee will audit 2 nurses weekly to verify competency on proper drug destruction. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the Pharmacist Consultant report was acted upon for 2 of 10 residents reviewed for unnecessary medications. (Residents #73 and #102)</p> <p>Findings include:</p> <p>1. The record for Resident #102 was reviewed on 4/25/13 at 2:40 p.m. The resident was readmitted to the facility on 1/13/13. The resident had diagnoses that included, but were not limited to, Alzheimer's disease, depression and dementing illness with associated behavioral symptoms.</p> <p>The readmission Physician Order Sheet dated 1/13/13, indicated the resident was to receive seroquel (an antipsychotic medication) 25 mg (milligrams) three times per day.</p> <p>The Pharmacist Consultant report</p>	F000428	<p>F. 428</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #73 was seen by psych services on 5/10 and recommendations were communicated and accepted by the physician. Resident #102 attending physician reviewed the Pharmacist Consultant report and properly indicated the diagnosis for the use of the Seroquel and indicated the symptom criteria for the use of the medication.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice is: An audit of the previous month's pharmacy recommendations was completed to ensure that the recommendations were accepted or denied and the supporting documentation was present.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: ADON and Social</p>	05/30/2013			

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	<p>dated 2/8/13, was reviewed. It indicated: "(Resident #102's name) receives an antipsychotic, Seroquel, but does not have appropriate associated diagnosis documented in the medical record. Federal nursing facility regulations require that antipsychotic agents be used only when one or more of the following conditions exists.</p> <ol style="list-style-type: none"> 1. Schizophrenia 2. Schizo-affective disorder 3. Delusional disorder 4. Mood Disorders (e.g. mania, bipolar disorder, depression with psychotic features, treatment of major refractory depression) 5. Schizophrenia disorder 6. Psychosis NOS (not otherwise stated) 7. Atypical psychosis 8. Brief psychotic disorder 9. Dementing illness with associated behavioral symptoms. 10. Medical illness or delirium with manic or psychotic symptoms and/or treatment-related psychosis or mania (e.g. thyrotoxicosis, neoplasms, high dose steroids) <p>In addition, the clinical condition being treated must also meet at least one of the following criteria for use: A) The symptoms are identified as being due to mania or psychosis</p>		<p>Service have been in-serviced by the Director of Nursing on 5/17/13 on the process for reviewing and ensuring timely follow up of pharmacy recommendations.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit 100 % of the pharmacy recommendations on a monthly basis to ensure that the recommendations were accepted or denied and the supporting documentation was present. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>(such as auditory, visuals or other hallucinations or delusions (e.g., paranoia or grandiosity); OR B) The behavioral symptoms present a danger to the resident or to others; OR C) The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g. crying , fear, continuously yelling, screaming, distress associated with end-of-life) a significant decline in function and/or substantial difficulty receiving needed care (e.g. not eating resulting in weight loss, fear, and not bathing leading to skin breakdown or infection). Recommendation: Please re-evaluate continued use of Seroquel and consider reducing the dose to 25 mg po BID (twice a day), with the eventual goal of discontinuation, if possible. If therapy is to continue as currently ordered, please indicate: the diagnosis requiring treatment (listed in 1-10 above) _____ AND the symptom criteria (listed in A-C above) _____."</p> <p>The Physician signed the form on 3/3/13, he indicated the diagnosis for the use of the Seroquel was</p>			

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	<p>"Dementing illness" he did not indicate the symptom criteria for the use of the medication.</p> <p>Interview with the Director of Nursing on 4/26/13 at 9:55 a.m., indicated the physician did not complete the form. She indicated the symptom criteria was not completed as required by the Pharmacist to meet the regulation.</p> <p>2. The record for resident #73 was reviewed on 4/24/13 at 2:55 p.m. The resident had diagnoses that included, but were not limited to, diabetes, dementia and hypothyroidism.</p> <p>The current Physician order dated April 2013, indicated the resident was receiving Valproic acid (Depakote) (a mood stabilizing medication) 250 mg (milligrams) orally once daily.</p> <p>The Pharmacist Consultant Report dated 2/8/13, was reviewed. It indicated:</p> <p>"Comment: BEHAVIOR MANAGEMENT MEETING: (Resident #73's name) has received Depakote 250 mg po (orally) HS (hour of sleep) since 5/12 for dementia with associated behaviors. Recommendation please evaluate</p>						

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	<p>current psychotropic regimen to ensure resident is receiving the lowest effective dose for her condition."</p> <p>The Physician signed the report on 2/19/13 and placed a check in the section that indicated: "I decline the recommendation above because GDR (gradual dose reduction) is clinically contraindicated for this individual as indicated below. (Note: Please check option #1 or #2 and provide patient-specific rationale on the lines below.)</p> <p>The Physician placed a check that indicated option #2: "The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. Please provide CMS (Centers for Medicare and Medicaid Services) required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual."</p>			

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	<p>The Physician did not provide the patient-specific rationale describing why a GDR attempt was likely to impair function or cause instability with the resident.</p> <p>Review of the physician progress notes dated 2/8/13, indicated there was no evidence of a patient-specific rationale as to why the GDR was contraindicated.</p> <p>Interview with the Social Service Director on 4/25/13 at 11:09 a.m., indicated the Physician did not provide the patient-specific rationale for the continued use of the Depakote.</p> <p>3.1-25(j)</p>				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure multi dose vials of insulin were labeled when opened for 2 of 2 units</p>	F000431	<p>F 431</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: There were no residents affected by</p>	05/30/2013			

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	<p>throughout the facility. This had the potential to affect eleven insulin dependent diabetics residing on the North Unit and seven insulin dependent diabetics residing on the South Unit. (Residents #35, #39, #48 and #53)</p> <p>Findings include:</p> <p>1. On 4/26/13 at 9:55 a.m., observation of the Medication Cart on the South Unit indicated the following:</p> <p>a. A vial of Humalog insulin for Resident #53, was not dated when opened.</p> <p>b. A vial of Novolog insulin for Resident #35 was not dated when opened.</p> <p>c. A vial of Novolog insulin for Resident #48 was not dated when opened.</p> <p>2. On 4/30/13 at 10:08 a.m., observation of the Medication Cart on the North Unit indicated the following:</p> <p>a. A vial of Lantus insulin for Resident #39 was not dated when opened.</p> <p>Review of the Medication Storage</p>		<p>the fact that the insulin vials were opened but not dated.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: On 5/24/13 the DON, ADON, SDC, Evening shift supervisor completed a audit of all medications to verify that there were no medications that were opened and unlabeled.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: In-service will be provided 5/24/13.to the licensed nurses by the DON on facility policy and procedure for properly labeling medications when initially opened.</p> <p>4. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit weekly 100 % of the insulin vials to verify that vials are labeled when opened. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>and Security Policy provided by the Director of Nursing on 4/30/13 at 11:25 a.m., indicated "the nurse always dates and initials insulin vials when opened."</p> <p>Interview with the Director of Nursing on 4/30/13 at 11:30 a.m., indicated the vials of insulin should have been labeled when opened.</p> <p>3.1-25(j)</p>			

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to marred walls, peeling dry wall, cracked and peeling material on wheelchair arms and legs, and areas of rust on the toilet lift seats on 2 of 2 units. This had the potential to affect the 72 residents residing in the facility. (The North and South Units)</p> <p>Findings include:</p> <p>1. During the Environmental tour on 4/30/13 at 1:55 p.m., the following was observed on the North Unit:</p> <p>a. The wheelchair arms for the resident residing in room 200A were torn and cracked. Two residents resided in this room.</p> <p>b. The wall behind the head of the bed in room 203A was scratched and marred. Two residents resided in this room.</p> <p>c. The wall behind the head of the bed in room 208 was scratched and</p>	F000465	F 465 1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents were affected by the requirement not being met and all environmental concerns identified during the survey have been addressed and/or resolved. The wheelchair arms for the resident residing in 200A were replaced, the walls behind the head of the bed in room 203A were repaired and repainted, the wall behind the head of the bed in room 208 was repaired and repainted, the outside of bathroom door in room 208 was sanded and restained, the toilet lift seat in room 217 was replaced, the wheelchair arm rest for the resident in room 101A have been replaced, the wall behind the head of the bed B in room 103 has been repaired and repainted, the wall located behind the sink in the bathroom for residents in room 105 and 107 has been repaired and repainted, the toilet paper holder in the bathroom for residents in room 104 and 106 has been replaced, as well as, the missing tiles and areas of peeling dry wall behind the sink has been repaired, the dry wall behind the sink in the bathroom in room 109 has been	05/30/2013			

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	<p>marred. The outside of the bathroom door was also scratched and marred. One resident resided in this room.</p> <p>d. The toilet lift seat in room 217 had areas of rust and missing paint. Two residents resided in this room.</p> <p>2. During the Environmental tour on 4/30/13 at 2:15 p.m., the following was observed on the South Unit:</p> <p>a. The wheelchair arm rests for the resident residing in room 101A were observed to be torn and cracked. Two residents resided in this room.</p> <p>b. The wall behind the head of bed B in room 103 was observed to be marred and torn.</p> <p>c. The wall located behind the sink in the bathroom serving the residents in rooms 105 and 107, were observed to have areas of peeling dry wall. Two residents resided in rooms 105 and 107.</p> <p>d. The toilet paper holder in the bathroom serving the residents in rooms 104 and 106 was broken. Further, there were missing tiles and areas of peeling dry wall behind the sink in the shared bathroom of rooms 104 and 106. Two residents resided</p>		<p>repaired and repainted, the wall behind the head of the bed in room 111A has been repaired and repainted, the toilet lift seat located in the bathroom in room 111A has been replaced, the dry wall behind the sink in the bathroom of room 114 has been repaired and repainted.2. The corrective action for those residents having the potential to be affected by the same deficient practice is: No residents were adversely affected due to the deficient practice.3. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur: The Maintenance Director has been in-serviced by the ED on 5/16/13 in regards to properly maintaining a functional and sanitary environment. 4. To ensure the deficient practice does not reoccur, the monitoring system established is: The Executive Director /designee will make weekly rounds to insure that the Maintenance Director is properly maintaining a functional and sanitary environment. The audits will be discussed during our monthly Performance Improvement Meeting. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		

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	<p>in rooms 104 and 106.</p> <p>e. The dry wall behind the sink in the bathroom of room 109 was peeling. One resident resided in this room.</p> <p>f. The wall behind the head of the bed in room 111A was scratched and marred. The toilet lift seat located in the bathroom had areas of rust and peeling paint. Two residents resided in this room.</p> <p>g. The dry wall located behind the sink in the bathroom of room 114 was peeling. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor at this time, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>			

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F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory services were provided as ordered related to obtaining a urinalysis for 1 of 10 residents reviewed for unnecessary medications. (Resident #85)</p> <p>Findings include:</p> <p>The record for Resident #85 was reviewed on 4/30/13 at 1:30 p.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, Alzheimer's dementia and depression.</p> <p>A Nursing progress note dated 3/30/13 at 1:36 a.m., indicated the resident was exhibiting agitated behavior, yelling, refusing to be changed and using foul language. The Physician was notified and a UA with C/S (urine test) was ordered at that time.</p> <p>Review of the laboratory results in the resident's record indicated no UA results were available. Further, the Nursing progress notes did not</p>	F000502	<p>F 502</p> <ol style="list-style-type: none"> The corrective action taken for the resident found to have been affected by the deficient practice: Resident # 85 physician was contacted regarding the missed collection of the lab specimen and new order obtained and collected on 4/30/2013. The corrective action for those residents having the potential to be affected by the same deficient practice: There were no other residents affected by the deficient practices as evidenced by the facility lab provider completed an audit of lab orders from the previous month to verify timely completion of ordered tests. The measures put into place and a systemic change made to ensure the deficient practice does not reoccur. In-service will be completed by 5/24/13 to the professional nurses by the DON on facility policy and procedure for properly collecting lab specimens. To ensure the deficient practice does not reoccur, the monitoring system established is: DON/designee will audit weekly 100 % of the ordered lab collection of specimens Monday through Friday, weekend issues will be reviewed on 	05/30/2013			

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	<p>indicate if a urine sample was obtained.</p> <p>Interview with the Director of Nursing on 4/30/13 at 2:45 p.m., indicated the UA had not been done at that time. She further indicated she had notified the physician that the test had not been completed and obtained an order to have a UA done as soon as possible.</p> <p>3.1-49(a)</p>		<p>Monday. PI committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p>		