

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
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F 0000 Bldg. 00	<p>This visit was for Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00199009 completed on 7/1/16.</p> <p>Survey dates: July 11, 12, 13, 14, 15, and 18, 2016.</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Census bed type: SNF/NF: 136 Total: 136</p> <p>Census payor type: Medicare: 17 Medicaid: 90 Other: 29 Total: 136</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on July 21, 2016</p>	F 0000	<p>Preparation and submission of this Plan of Correction does not constitute the admission or agreement by the Provider to the truth of the "findings" alleged or conclusions set forth in the Statement of Deficiencies (CMS-2567). The Plan of Correction is prepared, executed and submitted solely because it is required by the provisions of federal and state law.</p> <p>The Provider formally requests a desk review</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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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's call light was in reach for 1 observation and 1 of 17 residents. (Resident #33)</p> <p>Findings include:</p> <p>Resident #33's record was reviewed on 7/14/16 at 1:56 p.m. Physician's recapitulation orders, dated July 1, 2016, indicated diagnosis that included, but were not limited to, encephalopathy, atherosclerosis, acute kidney failure, type 2 diabetes mellitus, high blood fats, hypothyroidism, anxiety disorder, major depressive disorder, anemia, gastro esophageal reflux disorder, bladder structure problems, and urinary tract infection.</p> <p>A Quarterly Minimum Data Set</p>	F 0246	<p>I. The Facility failed to ensure that Resident # 33 call light was in reach while unattended in her room. Upon discovery, the call light was immediately placed within the resident's reach. II. The staff made immediate rounds on all other residents to ensure that call lights were within reach and no other resident was affected. III. Education was provided to all Staff regarding the call lights being within reach to all residents while in their rooms. IV. Call light audits will be performed by Unit Manager or designee weekly x 4 weeks then monthly for 6 months on all shifts to ensure compliance. Auditing will begin on 8/1/16. These audits will be taken to the monthly Performance Improvement Committee by the DNS. This Committee will decide if time frame needs extended based on audit findings.</p>	08/09/2016

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	<p>assessment, dated 5/19/16, indicated Resident #33 was severely impaired in cognitive skills for daily decision making, required extensive assistance of 2 for transfers, toilet use, and personal hygiene, and did not walk.</p> <p>A care plan, dated 3/17/14, had a focus of "Resident is high risk for falls r/t incontinence, fall risk assessment score. Goal: Resident will be free of falls through the review date. Interventions: Anticipate and meet resident's needs...Be sure the call light is within reach and encourage resident to use it for assistance as needed. Resident needs prompt response to all requests for assistance..."</p> <p>On 7/18/16 at 9:47 a.m., during an interview and observations, Resident #33 said she had go to the bathroom and repeated this statement several times. The resident sat in a specialty wheel chair watching TV and her call light was observed lying in the floor, at the head of her bed. The resident was seated beside the bed and the call light was in back of her on the floor.</p> <p>On 7/18/16 at 9:50 a.m., LPN #4 indicated the resident uses her call light and that activities had brought her back to her room and didn't attach her call light. She said they should know to put</p>			

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F 0279 SS=D Bldg. 00	<p>her call light where she could reach it.</p> <p>On 7/18/2016 at 9:52 a.m., the Activity Director indicated she had taken the resident to the nurses station and didn't know who took her on to her room.</p> <p>3.1-3(v)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and</p>	F 0279	I. The Facility failed to develop a	08/09/2016	

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	<p>record review, the facility failed to develop a plan of care for activities of daily living (ADL's) to coordinate resident care, develop a plan of care for hydration for a resident with a history of dehydration, and develop a plan of care for a resident who had received Lasix medication, for 3 of 20 residents reviewed for care plans. (Resident #55, #122, and #167)</p> <p>Findings include:</p> <p>Resident #55's record was reviewed on 7/13/16 at 1:35 p.m. His diagnosis documented on his July 2016 physician's recapitulation orders included but were not limited to, diabetes type II, diabetic neuropathy, enlarged prostate with lower urinary tract symptoms, hypertension, and depressive episodes.</p> <p>Resident #55's quarterly Minimum Data Set (MDS) assessment dated 5/19/16, indicated he was understood and had the ability to understand others. He was cognitively intact for his daily decision making skills. He required supervision of 1 person for bed mobility, transfer, toileting, personal hygiene, and eating. He required limited assistance of 1 person to dress. He required limited assistance of 1 person to walk in his room and utilized a walker and</p>		<p>care plan for Resident #55 for ADLs, Resident #122 for hydration, and Resident #167 for medication of Lasix. The Facility added the care plan for resident #167 for Lasix on 7/14/16. The Facility added a care plan for resident #55 for ADLs on 7/27/16. Resident #122 was discharged from the Facility for a planned psychiatric care stay. His care plan will be added upon his return for "at risk of dehydration". II. All residents have the potential to be affected by the Facilities deficient practices. III. Education has been provided to all licensed staff on the Facilities care plan policy. All current resident charts will be audited to ensure each resident's care plan actively reflects any current diagnosis, allergy that is severe, ADLs, code status, pain, and at risk conditions by the IDT. The IDT will audit each new admit after the 5 day initial assessment period and update care plans as needed, as well as any significant change in condition or any order change. IV The IDT will take the results of the audit to Performance Improvement Committee monthly for 6 months and re-educate as needed.</p>				

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	<p>wheelchair.</p> <p>A "Health Status Note" for Resident #55 dated 6/1/16 at 10:38 a.m., indicated he was at risk for falls, diminished safety awareness, and poor vision related to glaucoma.</p> <p>On 7/12/16 at 10:29 a.m., Resident #55 indicated he could brush his own teeth and dentures. He indicated his denture brush disappeared and he had quit wearing his dentures because he could not see well enough to put the adhesive on them. He indicated there were some staff who would help him with it.</p> <p>An interview with Unit Manager #13 on 7/13/16 at 2:23 p.m., indicated Resident #55 received his showers on Monday and Thursday evening and received oral care twice a day. Resident's showers and oral care were documented by staff in the Kiosk. No plan of care had been developed for Resident #55's bathing or oral care except where the staff documented in the Kiosk.</p> <p>On 7/13/16 at 2:30 p.m., during and interview with Resident #55, he was observed to have some lower teeth that were yellowish in color. He had some dentures in a denture cup on his bedside table. Resident #55 indicated he used to</p>			

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	<p>have a denture brush but didn't know what happened to it. He had practically quit wearing his dentures because he used his walker to go to the bathroom sink and he had to hold onto something and it made it difficult for him to clean his dentures and put adhesive on them. He could take his wheelchair to the bathroom sink but an arm on the toilet made it difficult to get close to the sink. He hadn't been asking for staff assistance because he felt staff didn't want to help him. He had been told he could practically do everything himself. His wife was visiting him at the time of the interview and she found his denture brush in a bag attached to his walker. He had miscellaneous grooming items in the bag and in a plastic tub in his closet. His wife indicated he had very poor vision and he had not recognized her that day when she entered his bedroom and had recognized her voice when she spoke with him.</p> <p>An interview with CNA #9 on 7/13/16 at 3:49 p.m., indicated Resident #55 brushed his own teeth in the bathroom after staff set up his supplies and put toothpaste on his toothbrush. It depended on how Resident #55 felt that day if he used his walker or wheelchair to go to the bathroom. She didn't think he had dentures but she couldn't actually remember but "he may have a partial."</p>						

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	<p>She had never observed Resident #55 have any trouble brushing his own teeth. If he was in his wheelchair in the bathroom he would propel his wheelchair close to the sink and then stand up at the sink and brush his teeth. Sometimes he didn't like asking for help because he felt like he was bothersome to staff.</p> <p>On 7/14/16 at 9:38 a.m., Resident #55 indicated he had not brushed his teeth that morning. His denture cup was on his bedside table.</p> <p>On 7/14/16 at 9:56 a.m., CNA #10 indicated Resident #55 had asked her to help him change his pants that morning and she had been surprised because he usually didn't ask for help getting dressed. Resident #55 had not requested any further help after she had assisted him with his pants. She was informed in report he was mostly independent. He walked with a walker and was not an extensive assist.</p> <p>On 7/14/16 at 9:58 a.m., Resident #55 agreed for CNA #10 to assist him with his oral care while he was in the bathroom with his walker. CNA #10 gathered Resident #55's oral care supplies and he requested his wheelchair. CNA #10 took Resident #55 his wheelchair and removed his walker from the</p>			

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	<p>bathroom. CNA #10 positioned Resident #55's wheelchair as close to the bathroom sink as possible and he remained seated. She placed toothpaste on his toothbrushes and he brushed his teeth and dentures. She applied adhesive to his dentures and he placed them in his mouth.</p> <p>On 7/14/16 at 4:25 p.m., CNA #11 indicated Resident #55 would take his own supplies into his bathroom and stand from his wheelchair and brush his teeth. Resident #55 did not require any assistance and CNA #11 would stand behind Resident #55 while he brushed his teeth. CNA #11 did not believe Resident #55 wore any dentures or partials.</p> <p>On 7/18/16 at 4:13 p.m., Case Manager #12 indicated a plan of care had not been developed for Resident #55 specific to ADL's. Resident #55 required supervision to limited assistance. His need for set up with meals was documented on his diet plan of care. He had 1 assistance with his suprapubic catheter and he was encouraged to prop his feet up as needed. He was encouraged to call for assistance if needed. "We incorporated those type of things in with his other care plans." She was going to schedule a new MDS assessment. Staff would be able to speak with Resident #55 about how he felt and</p>			

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	<p>what he needed, so if he felt he needed more assistance his care plans could be updated.</p> <p>On 7/18/16 at 5:52 p.m., Resident #55's wife indicated Resident #55 needed assistance with his personal hygiene, cleaning his teeth, and placing his dentures in his mouth. He could do a lot for himself but his eyesight was poor and he needed assistance with his personal care.</p> <p>2. Resident #122's record was reviewed on 7/15/16 at 11:35 a.m. His diagnoses documented on his July 2016 physician's recapitulation orders included but were not limited to, Parkinson's disease, dementia with behavioral disturbances, altered mental status, hypertension, anemia, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, acute and chronic respiratory failure, type II diabetes, and kidney failure.</p> <p>Resident #122's quarterly MDS assessment dated 5/31/16, indicated he was understood and had the ability to understand others. He was cognitively intact in his daily decision making skills. He was not dehydrated and received a diuretic medication.</p>			

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	<p>A physician's order for Resident #122 dated 6/25/16 at 5:00 p.m., indicated he would receive 1 liter intravenously of sodium chloride 0.9% solution 1 time only at 96 milliliters (ml) an hour (hr) times 1 after initial bag, then at 200 ml/hr.</p> <p>A physician's order for Resident #122 dated 6/26/16 at 12:05 p.m., indicated he would receive a Basic Metabolic Panel (BMP) laboratory test 1 time a day for increased lab values.</p> <p>A physician's order for Resident #122 dated 6/26/16 at 12:16 p.m., indicated he would receive sodium chloride 0.9% solution at 100 ml/hr every 12 hours intravenously for lab values continuously.</p> <p>A physician's order for Resident #122 dated 6/30/16 at no time, indicated he would receive a BMP laboratory test in the a.m., for a diagnosis of dehydration.</p> <p>A "Progress Note" for Resident #122 dated 6/30/16 at 8:15 p.m., indicated his intravenous fluids had been discontinued and a BMP laboratory test would be obtained the next morning.</p>			

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	<p>A "Dehydration Screening" for Resident #122 dated 7/2/16, indicated he had no signs or symptoms of dehydration.</p> <p>An interview with Resident #122 on 7/12/16 at 10:04 a.m., indicated he hadn't received the fluids he wanted between meals because he was only offered water.</p> <p>An interview with Resident #122 on 7/14/16 at 9:43 a.m., indicated staff only offered him water between meals. He had asked for Coke to drink when he first started residing at the facility but was informed if he wanted Coke to drink he would have to buy it. He was offered orange juice and kool-aide at meal time and he liked those. He felt like he did not receive enough fluids to drink because he only drank approximately half of his water.</p> <p>An interview with CNA #10 on 7/14/16 at 9:53 a.m., indicated fresh water was passed every shift. If a resident requested something to drink besides water, staff could get them something from the pantry or kitchen.</p> <p>On 7/15/16 a 9:50 a.m., Resident</p>			

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F 0309 SS=G Bldg. 00	<p>#122 was observed seated on the side of his bed drinking water from a Styrofoam cup independently.</p> <p>An interview with Unit Manager #13 on 7/18/16 at 3:09 p.m., indicated no hydration plan of care had been developed for Resident #122. Resident #122's intravenous fluids had started on 6/24/16 and had been discontinued on 6/30/16. His dehydration had happened so quickly was why she believed a plan of care for hydration had not been developed.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to monitor frequency of bowel movements (BM), provide interventions for constipation, notify the physician of a resident not having a bowel movement for 7 days, failed to administer PRN (as needed) medication for constipation resulting in 1 resident being hospitalized for a fecal impaction and failed to</p>	F 0309	I. The Facility failed to notify MD of resident's condition which resulted in fecal impaction for Resident #182. The incident regarding Resident #182 was resolved prior to the start of the annual survey. Upon readmission to the Facility, interventions for a bowel regimen were ordered by MD and effective at the time. Resident #169 records were reviewed and resident has had no	08/09/2016

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	<p>correctly assess a resident receiving lasix (diuretic medication) for 1 of 3 residents reviewed for quality of care (Resident #182, Resident #169 and Resident #167).</p> <p>Findings include:</p> <p>1.) During observation on 7/11/16 at 1:48 p.m., Resident #182 was laying in bed on his back with his eyes open, the resident did not respond verbally.</p> <p>During an interview with Resident #182's family member #1 on 7/12/16 at 11:41 a.m., indicated the resident had recently been discharged to the hospital. The family member indicated the facility had not been communicating about the resident's lack of bowel movements and the resident ended up with a fecal impaction and was throwing up bowel movement. The family member indicated the facility was "not on top" of the situation sufficiently.</p> <p>Review of the record of Resident #182 on 7/13/16, the resident's diagnoses included, but were not limited to, constipation, cerebellar ataxia (cerbellum (part of the brain responsible for controlling gait and muscle coordination) becomes inflamed or damaged with the loss of control of bodily movements),</p>		<p>incident since the survey occurred where resident has gone more than 3 days without having a bowel movement. Resident is continent and independently transfers self to bathroom. Facility feels resident may not always report bowel movements accurately. Resident takes immodium daily as ordered by her MD for a history of frequent loose stools. A Nursing Order has been added to the Resident's MAR to question the Resident every shift about bowel movements. Resident #167 received 82 dosages. The order was entered inaccurately and was intended to be BID indefinitely. The MD ordered labs and potassium. The results were within normal limits. II. All residents have the potential to be affected by the Facilities deficient practice. The Facility reviewed all residents flagging for no bowel movement on the Dashboard and ensured that the appropriate interventions are in place and effective. All other Residents receiving a diuretic therapy were reassessed to ensure that accurate documentation has been made III. Re-education has been provided to all nursing staff regarding notification of bowel movements or lack there of to licensed nursing staff and MD. Every resident flagging for no BM on day three will have notification to MD for intervention. Those residents with interventions</p>	

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	<p>esophageal reflux disease, insomnia, seizures, anxiety and major depressive disorder.</p> <p>The Admission Minimum Data (MDS) assessment for Resident #182, dated 4/25/16, indicated the resident had no speech, was unable to make himself understood rarely/never and was severely impaired for daily decision making. The resident required extensive assistance of two people for bed mobility, transfers, toilet use and personal hygiene. The resident was unable to ambulate. The resident was always incontinent of his bowels and bladder. The resident's nutritional approach was a feeding tube (device inserted into the stomach to supply nutrition).</p> <p>The physician order for Resident #182, dated May 2016, indicated the resident was to have bisacodyl suppository 10 milligrams (mg) rectally every 24 hours as needed for constipation and soap suds enema every 24 hours as needed for constipation if the resident does not have one bowel movement a day.</p> <p>The bowel movement record for Resident #182, dated May 2016, indicated the resident did not have a bowel movement on 5/4/16, 5/5/16 or 5/6/15. The May 2016 Medication Administration Record</p>		<p>already on order will be administered. MD notification will occur each day until expected results are achieved. Each licensed nurse was re-educated on our MD and family notification and instructed to make a progress note after notification of both parties with current intervention. IV. The IDT will audit bowel movements daily using the Dashboard. IDT will monitor Administration record weekly to verify administration of prn medications. The UM or designee will audit the electronic clinical record assessments for accuracy, 3 times a week. Results of these audits will be taken to the Performance Improvement Committee monthly for 6 months and re-education will be provided as needed.</p>		

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	<p>(MAR) indicated the resident did not receive the bisacodyl suppository 10 mg or the soap suds enema on these days as ordered by the physician.</p> <p>The physician order for Resident #182, dated June 2016, indicated the resident was ordered bisacodyl suppository 10 mg rectally every 24 hours as needed for constipation. The bowel movement record for Resident #182 indicated the resident did not have a bowel movement on 6/19/16 and 6/20/16. The MAR indicated the resident did not receive the bisacodyl suppository on 6/19/16 or 6/20/16.</p> <p>The bowel movement record dated from 6/28/16 to 7/4/16 indicated the resident not have a bowel movement, this indicated the resident went 7 days without a bowel movement. The MAR for Resident #182 indicated the resident did not receive the bisacodyl suppository 10 mg as ordered by the physician on 6/28/16, 6/29/16, 6/30/16, 7/1/16, 7/2/16, 7/3/16 or 7/4/16.</p> <p>The progress note for Resident #182, dated 7/4/16 at 1:19 p.m., indicated the resident had vomited. The vomit had the appearance of tube feeding. The resident's tube feeding was put on hold and the resident will be monitored. The</p>			

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	<p>progress note was electronically signed by LPN #6.</p> <p>The progress note for Resident #182, dated 7/4/16 at 6:17 p.m., indicated the resident vomited again. The resident was placed on his left side, resident's lungs were clear. Suctioning equipment was hooked up at the bedside and the resident's mouth was suctioned, with nothing suctioned out at this time. The resident was being sent to the emergency room at this time per the Nurse Practitioner.</p> <p>The facility transfer to the hospital form for Resident #182, dated 7/4/16 at 6:32 p.m., indicated the resident was sent to the hospital for "vomiting stool."</p> <p>The progress note for Resident #182, dated 7/4/16 at 7:00 p.m., indicated the local ambulance picked up the resident and transported him to the Emergency Room (ER).</p> <p>The Nurse Practitioner for Resident #182, dated 7/4/16 at 9:16 p.m., indicated she had been asked to see the resident for nausea and vomiting. The resident had problems with ileus (inability of the bowels to contract normally and move waste out of the body) in the past. "I am unsure when his last BM was." The</p>			

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	<p>resident was not tolerating his tube feeding and his abdomen was firm. The resident's bowel sounds were hypoactive.</p> <p>The local ER note for Resident #182, dated 7/4/16 at 7:26 p.m., indicated the resident presented to the ER secondary to black tarry emesis. The resident had a history of cerebellar ataxia, is nonverbal and was bedridden. The resident had G-tube and does not take anything by mouth. The resident's family member #2 reported that he had a low grade fever for the past several days and had not been acting like himself. "Today he began vomiting, and his emesis was black in color and smelled like stool." The family member reported "the last time this occurred, he was found to be severely impacted with stool and had spent four days in the hospital getting enema and disimpactions."</p> <p>The "abdomen/pelvis CT (x-ray computed tomography) scan for Resident #182, dated 7/4/17 12:00 a.m., indicated there were "Marked gaseous distention throughout the colon and moderate small bowel gaseous distention." "Large fecal impaction in the rectum."</p> <p>The "discussion of ED (emergency department) course" for Resident #182, dated 7/4/16, indicated "28-year old male</p>			

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	<p>who presented to the emergency department from" the facility secondary to emesis. "At the time of examination, the patient was found to be quite thin, dehydrated, and chronically ill-appearing." "His abdomen was firm and distended and diffusely tender to palpation." " The patient did have a couple episodes of dark brown emesis which was feculent smelling." "The G-tube was then aspirated with a large syringe, at which time a plug in the tubing dislodged and the G-tube began draining dark brown stomach contents." "Approximately 220 milliliters (ML) of fluid was suctioned from the patients stomach." "I did attempt to manually disimpact the patient and was able to remove a moderate amount of clay consistency brown stool." The case was discussed with another physician and the resident was admitted for further treatment.</p> <p>The hospital discharge summary for Resident #182, dated 7/6/16, indicated the discharge diagnosis was "fecal impaction." The resident was "admitted for fecal impaction and given mag citrate through PEG tube once vomiting controlled after gastric decompression in ER." "Bowel function returned" and patient "stooled multiple times." "Will need a more aggressive bowel regimen"</p>			

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	<p>or reduced opiod use. "Will start movantic to prevent further constipation." "OK if patient has loose BM's- medication should not be stopped for this reason." "Frequent changing and turning will be needed to prevent skin breakdown."</p> <p>Interview with the Assistant Director Of Nursing Services (ADNS) on 7/15/16 at 10:40 a.m., indicated she was unable to find documentation that Resident #182 received any PRN medication for constipation from 6/28/16 to 7/4/16. The ADNS indicated the facility does not have a bowel movement protocol. The ADNS indicated the CNA's and nursing staff chart BM's and report to the nurse if they have any concern. The ADNS indicated the physician would be notified if the resident had signs and symptoms of constipation.</p> <p>Interview with the Director Of Nursing Services (DNS) on 7/18/16 at 1:43 p.m., indicated Resident #182 did not receive any PRN's for constipation prior to his hospitalization on 7/4/16. The DNS indicated the facility did not have an elimination policy or an elimination assessment policy. The DNS indicated in the daily report the "dash board will say" a resident had went without a BM after three days. The DNS indicated she was</p>			

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	<p>unsure what happened with Resident #182 during the time between 6/28/16 and 7/4/16 when the resident did not have bowel movement, the DNS indicated it was "notification". When queried how did the facility assess what a normal bowel movement function would be for residents, the DNS indicated they ask the resident or their family. The DNS indicated the facility was aware that Resident #182 had a history of fecal impaction and constipation from his family member.</p> <p>Interview with Resident #182 family member #2 on 7/18/16 at 3:06 p.m., indicated on 7/4/16 the resident stomach was firm/distended and the resident was vomiting. Family member #2 indicated the resident had been hospitalized prior to coming to the facility for constipation and the facility had been made aware of this. Family member #2 indicated on 7/4/16 they had requested LPN #6 to check and see when the resident had their last bowel movement. Family member #2 indicated then the facility called the NP and sent him to the hospital. Family member #2 indicated if the resident had not had a bowel movement by the third day, the facility needed "to be doing something."</p> <p>Interview with LPN #6 on 7/18/16 at</p>			

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	<p>4:08 p.m., indicated he was the nurse caring for Resident #182 on 7/4/16 when the resident was sent to the hospital. LPN #6 indicated a CNA had notified him that the resident had vomited. LPN #6 indicated the vomit appeared to look like tube feeding, so he raised the resident's head of the bed higher. LPN #6 indicated he had asked the resident if his stomach felt full and the resident shook his head yes. LPN #6 indicated it was not reported to him that the resident had not had a bowel movement for 6 days. LPN #6 indicated he would normally notify the physician if a resident had not had a bowel movement after 3 days. LPN #6 indicated normally residents would have a PRN medication for constipation and they were effective.</p> <p>2. Resident #169's record was reviewed on 7/14/16 at 3:47 p.m. Her diagnoses documented on her July 2016 physician's recapitulation orders indicated but were not limited to, dementia without behavioral disturbances, osteoarthritis, and hereditary and idiopathic neuropathy.</p> <p>Resident #169's quarterly MDS assessment dated 6/2/16, indicated she was understood and had the ability to understand others. She was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 1 person for bed mobility,</p>			

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	<p>transfer, dressing, and toileting. She was continent of bowel.</p> <p>Resident #169's bowel movements documentation for May 2016 indicated she had not had a bowel movement May 13th, 14th, 15, 16th, and 17th. She had a hard constipated stool on May 18th, She had no bowel movement on May 19th. She had a hard constipated stool on May 20th.</p> <p>Resident #169's bowel movements documented for June 2016 indicated she had not had a bowel movement on June 11th, 12th, 13th, 14th, 15th, 16th, and 17th. She had a hard constipated stool on June 18th. She had no bowel movement on June 19th and 20th.</p> <p>Resident #169's bowel movements documented for July 2016 indicated she had not had a bowel movement on July 4th, 5th, 6th, 7th, 8th, 9th, and 10th.</p> <p>An interview with Unit Manager #13 on 7/18/16 at 4:31 p.m., indicated Resident #169 took Immodium daily. Resident #169 had not received any as needed medication to promote bowel stimulation because she had not had an order for an as needed medication to promote bowel stimulation.</p>			

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review the facility failed to assist a resident with getting dressed and proper oral care as required for 2 of 3 residents reviewed for assistance with activities of daily living (Resident #259 and Resident #55).</p> <p>Findings include:</p> <p>1.) Interview with Resident #259 on 7/12/16 at 10:23 a.m., indicated she did not receive assistance she needed with getting dressed and oral care. Resident #259 indicated she was blind and needed assistance with both getting dressed and brushing her teeth. Resident #259 indicated her teeth needed brushed at this time. Resident #259 indicated she felt staff should assist her with getting dressed every day and often she was left in a gown. The resident indicated she liked getting dressed every day. Observation of Resident #259 at this time, she was in a gown. During observation on 7/13/16 at 1:22</p>	F 0312	<p>I. The Facility failed to provide assistance with ADLs regarding bathing, dressing and oral care for Resident #259 and Resident #55. Resident #259 discharged from the Facility on 7/18/16. The Facility was unable to correct the concerns due to the information from survey given on the day of discharge. Resident #55 was interviewed by staff for preferences with assistance on bathing and oral care. CNA Assignment Sheets have been updated for Resident #55 to reflect their preferences at this time. Resident #55 complained of bladder spasms causing occasional incontinence at night and this information has been communicated to the MD for new orders. Resident #55 does have a supra pubic catheter in place with active MD orders for care. II. All residents have the potential to be affected by the Facilities deficient practice. No other residents have been identified as being affected by the deficient practice. III. Each resident will be interviewed upon admission using Abaqis and quarterly with their care plan meeting for preferences and they will also be asked if they feel that</p>	08/09/2016			

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	<p>p.m., Resident #259 was sitting in her recliner in a gown and a jacket. The resident indicated staff had not helped her get dressed or helped her brush her teeth today.</p> <p>During observation on 7/14/16 at 10:30 a.m., Resident #259 indicated her daughter helped her brush her teeth yesterday and she had not had them brushed today. The resident was observed in a gown and a jacket. The resident indicated staff had not helped her get dressed today.</p> <p>During observation on 7/14/16 at 2:35 p.m., Resident #259 was sitting in her recliner with a gown and a jacket on. The resident had a visitor.</p> <p>Review of the record of Resident #259 on 7/18/16 at 4:30 p.m., indicated the resident's diagnoses included, but were not limited to, lung cancer, hypertension, weakness, arthritis and legal blindness.</p> <p>The Admission Minimum Data (MDS) assessment for Resident #259, dated 7/6/16, indicated the resident was admitted to the facility on 6/18/16. The resident was independent and reasonable for daily decision making, she had the ability to understand others and make herself understood. It was very important</p>		<p>their needs are being met in regards to ADL care. Each resident's care preference will be updated on the CNA assignment sheet and care planned to reflect the level of care needed to provide the assistance with ADLs as preferred. Every resident will be offered assistance on each shift. This approach will begin on admission and continue quarterly thereafter. The results of the interviews will be analyzed for any concerns of not meeting ADL needs or preferences. IV. The results will be taken to the Performance Improvement Committee monthly for 6 months until the facility agrees the deficient practice has been corrected.</p>	

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	<p>to her to choose what clothes to wear.</p> <p>The resident required extensive assistance of one person to get dressed and personal hygiene (including brushing teeth).</p> <p>The Activity of daily living record for Resident #259 dated from 6/18/16 to 7/17/16 indicated the resident did not receive assistance with oral care 19 times.</p> <p>Interview with CNA #8 on 7/18/16 at 11:55 a.m., indicated she knew which residents required assistance with Activities of Daily Living (ADL's) by the cna assignment sheet. Observation of the cna at this time indicated Resident #259 required assistance of one person for ADL's.</p> <p>2. Resident #55's record was reviewed on 7/13/16 at 1:35 p.m. His diagnosis documented on his July 2016 physician's recapitulation orders included but were not limited to, diabetes type II, diabetic neuropathy, enlarged prostate with lower urinary tract symptoms, hypertension, and depressive episodes.</p> <p>Resident #55's quarterly Minimum Data Set (MDS) assessment dated 5/19/16, indicated he was understood and had the ability to understand others. He was cognitively intact for his daily decision</p>			

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	<p>making skills. He required supervision of 1 person for transfer, toileting, personal hygiene, and eating. He required limited assistance of 1 person to dress. He required limited assistance of 1 person to walk in his room and utilized a walker and wheelchair.</p> <p>A "Health Status Note" for Resident #55 dated 6/1/16 at 10:38 a.m., indicated he was at risk for falls, diminished safety awareness, and poor vision related to glaucoma.</p> <p>A "Resident Care Sheet" for Resident #55 dated 7/12/16, indicated he required assistance of 1 person for mobility and transfer, and ADL's.</p> <p>On 7/12/16 at 10:29 a.m., Resident #55 indicated he could brush his own teeth and dentures. He indicated his denture brush disappeared and he had quit wearing his dentures because he could not see well enough to put the adhesive on them. He indicated there were some staff who would help him with it.</p> <p>An interview with Social Service (SS) Staff #14 on 7/13/16 at 2:18 p.m., indicated Resident #55 did not receive his ancillary services at the facility. No plan of care had been developed related to his dental status or oral care.</p>			

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	<p>On 7/13/16 at 2:30 p.m., during and interview with Resident #55, he was observed to have some lower teeth that were yellowish in color. He had some dentures in a denture cup on his bedside table. Resident #55 indicated he used to have a denture brush but didn't know what happened to it. He had practically quit wearing his dentures because he used his walker to go to the bathroom sink and he had to hold onto something and it made it difficult for him to clean his dentures and put adhesive on them. He could take his wheelchair to the bathroom sink but an arm on the toilet made it difficult to get close to the sink. He hadn't been asking for staff assistance because he felt staff didn't want to help him. He had been told he could practically do everything himself. His wife was visiting him at the time of the interview and she found his denture brush in a bag attached to his walker. He had miscellaneous grooming items in the bag and in a plastic tub in his closet. His wife indicated he had very poor vision and he had not recognized her that day when she entered his bedroom and had recognized her voice when she spoke with him.</p> <p>An interview with CNA #9 on 7/13/16 at 3:49 p.m., indicated Resident #55 brushed his own teeth in the bathroom</p>			

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	<p>after staff set up his supplies and put toothpaste on his toothbrush. It depended on how Resident #55 felt that day if he used his walker or wheelchair to go to the bathroom. She didn't think he had dentures but she couldn't actually remember but "he may have a partial." She had never observed Resident #55 have any trouble brushing his own teeth. If he was in his wheelchair in the bathroom he would propel his wheelchair close to the sink and then stand up at the sink and brush his teeth. Sometimes he didn't like asking for help because he felt like he was bothersome to staff.</p> <p>On 7/14/16 at 9:38 a.m., Resident #55 indicated he had not brushed his teeth that morning. His denture cup was on his bedside table.</p> <p>On 7/14/16 at 9:56 a.m., CNA #10 indicated Resident #55 had asked her to help him change his pants that morning and she had been surprised because he usually didn't ask for help getting dressed. Resident #55 had not requested any further help after she had assisted him with his pants. She was informed in report he was mostly independent. He walked with a walker and was not an extensive assist.</p> <p>On 7/14/16 at 9:58 a.m., Resident #55</p>			

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	<p>agreed for CNA #10 to assist him with his oral care while he was in the bathroom with his walker. CNA #10 gathered Resident #55's oral care supplies and he requested his wheelchair. CNA #10 took Resident #55 his wheelchair and removed his walker from the bathroom. CNA #10 positioned Resident #55's wheelchair as close to the bathroom sink as possible and he remained seated. She placed toothpaste on his toothbrushes and he brushed his teeth and dentures. She applied adhesive to his dentures and he placed them in his mouth.</p> <p>On 7/14/16 at 4:25 p.m., CNA #11 indicated Resident #55 would take his own supplies into his bathroom and stand from his wheelchair and brush his teeth. Resident #55 did not require any assistance and CNA #11 would stand behind Resident #55 while he brushed his teeth. CNA #11 did not believe Resident #55 wore any dentures or partials.</p> <p>On 7/18/16 at 5:52 p.m., Resident #55's wife indicated Resident #55 needed assistance with his personal hygiene, cleaning his teeth and placing his dentures in his mouth. He could do a lot for himself but his eyesight was poor and he needed assistance with his personal care.</p>			

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F 0323 SS=D Bldg. 00	<p>3.1-38(a)(2)(A) 3.1-38(a)(3)(C)</p> <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 observation, interview and record review, the facility failed to maintain a resident's head of the bed elevated while a tube feeding (artificial nutrition into the stomach) was being administered to prevent aspiration for 1 of 1 resident reviewed for accidents (Resident #182).</p> <p>Finding include:</p> <p>Review of the record of Resident #182 on 7/13/16 at the resident's diagnoses included, but were not limited to, constipation, cerebellar ataxia (cerbellum (part of the brain responsible for controlling gait and muscle coordination) becomes inflamed or damaged with the loss of control of bodily movements), esophageal reflux disease, insomnia, seizures, anxiety and major depressive</p>	F 0323	<p>I. The Facility failed to ensure the safety of the resident, leaving the head of his bed lower than 30 degrees after care was provided while receiving artificial nutrition via gastric tube. The resident HOB was immediately elevated to higher than 30 degrees. The resident was assessed by a nurse and the MD was notified. No negative outcomes were noted. II. Every resident with a gastric tube is at risk of being affected by the Facilities deficient practice. All Residents with gastric tubes were immediately assessed for proper elevation of head of bed. No other Residents were found to be affected. Education began immediately on the Enteral Feeding policy to correct this action and was provided to all staff. All beds of those Residents with gastric tubes are marked to indicate the angle of the bed to meet the 30 degree elevation.</p>	08/09/2016

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	<p>disorder.</p> <p>The Admission Minimum Data (MDS) assessment for Resident #182, dated 4/25/16, indicated the resident had no speech, was unable to make himself understood rarely/never and was severely impaired for daily decision making. The resident's nutritional approach was a feeding tube (device inserted into the stomach to supply nutrition).</p> <p>The plan of care for Resident #182, dated 4/22/16, indicated the resident required tube feeding and was at risk for aspiration. The interventions included, but were not limited to, the resident needed the head of the bed elevated 30-45 degrees during and thirty to sixty minutes after feeding was stopped.</p> <p>The physician order for Resident #182, dated 7/4/16 (no time), indicated the resident was ordered to have the head of the bed up 45 degrees.</p> <p>The physician order for Resident #182, dated 7/11/16 (no time), indicated the resident was ordered isosource 1.5 at 65 milliliters (ml) per hours for 20 hours. "</p> <p>During observation on 7/14/16 at 1:48 p.m., Resident #182 was laying flat in bed with his feeding tube running at 65 ml/hr. The resident was moaning and had</p>		<p>Immediate education will be provided during observation if necessary. III. Random weekly audits will be conducted by IDT to assess the degree of head of bed while receiving enteral nutrition for each resident x 4 weeks and then as need thereafter. IV. The results will be taken by the DNS or designee to the Performance Improvement Committee for 6 months and further if needed as determined by the Committee.</p>				

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	<p>facial grimacing. The call light was pushed.</p> <p>During observation on 7/14/16 at 1:50 p.m., CNA #5 came into Resident #182's room and indicated she did not know who laid the resident flat with tube feeding being administered. CNA #5 raised the resident's head of the bed up and went to get the nurse. Resident #182 stopped moaning.</p> <p>During observation on 7/14/16 at 1:53 p.m., LPN #6 listened to Resident #182's lungs and indicated they were clear. LPN #6 indicated he was not aware who laid the resident flat. LPN #182 raised the head of the bed higher and indicated he was going to notify the physician for further direction.</p> <p>Interview with the Director Of Nursing Services (DNS) on 7/14/16 at 2:22 p.m., indicated CNA # 7 was caring for Resident #182. The DNS indicated she was not sure who laid the resident flat with the tube feeding running. The DNS indicated it communicated to the aides on the cna assignment sheet which residents require the head of the bed to be elevated.</p> <p>Interview with CNA #7 on 7/14/16 at 2:03 p.m., indicated she was caring for Resident #182, but did not think she had</p>			

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	<p>laid the resident flat with the tube feeding running. CNA #7 indicated she was aware that the resident's head of the bed needed to be elevated by her cna assignment sheet. CNA #7 provided her cna assignment sheet and it did indicate the resident was to have the head of bed elevated. CNA #7 indicated when the DNS had talked to her about the resident laying flat, she did not tell the DNS that she did not think she had laid the resident flat with the tube feeding running, because she was caring for him and should have been checking on him.</p> <p>Interview with LPN #6 on 7/14/16 at 2:06 p.m., indicated the physician had given him orders for Resident #182 to hold the tube feeding for two hours and to keep the head of the bed up. LPN #6 indicated the facility would continue to do respiratory assessments on the resident.</p> <p>Interview with the Assistant Director Of Nursing Services (ADNS) on 7/15/16 at 9:55 a.m., indicated Resident #182 did not have a history of aspiration while at the facility.</p> <p>The enteral nutrition policy provided by the DNS on 7/15/16 at 12:40 p.m., indicated when a patient is fed by a tube the head of the bed should be at 30-45</p>			

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F 0329 SS=E Bldg. 00	<p>degrees.</p> <p>3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview the facility failed to ensure one resident's medication regimen was free</p>	F 0329	I. The Facility failed to ensure the resident medication regimen was free from unnecessary drugs with adequate monitoring for Resident #167. The Facility reviewed the need for the medication with the	08/09/2016	

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	<p>from unnecessary drugs in that a diuretic was given without a physician's order and without adequate monitoring. This affected 1 of 6 residents reviewed for unnecessary medications. (Resident #167)</p> <p>Findings include:</p> <p>Resident #167's record was reviewed on 7/13/16 at 1:17 p.m. Physician's recapitulation orders, dated July 2016, indicated Resident #167 had diagnoses that included, but were not limited to, Alzheimer's disease, hypothyroidism, atherosclerotic heart disease, osteoarthritis, high blood pressure, and gastro-esophageal reflux disease.</p> <p>A Quarterly Minimum Data Set assessment, dated 6/1/16, indicated Resident #167 had severe impairment in cognitive skills for daily decision making, required stand by assist with walking, and received a diuretic 7 times in the last 7 days.</p> <p>Progress notes, dated 4/10/16 at 9:04 p.m. indicated: "Resident has bilateral (both sides) swelling 1+ lower extremities, elevated legs at bedtime. Put resident on list to see dr for possible Lasix Rx (prescription)."</p>		<p>MD group and new orders were received. Labs were drawn and findings were within normal values. II. All residents have the potential to be affected by the Facilities deficient practice. The Facility reviewed all medication orders for transcription accuracy for all residents using the Order Summary Report. All licensed staff were re-educated on the policy regarding Physician orders, Reordering, changing, and discontinuing orders as well as Medication Regimen Review. III. Chart audits are to be performed by night shift daily and then weekly by Ums. All orders are reviewed by IDT in clinical meeting for accuracy and began on 7/26/16. The UM will audit each chart monthly for order accuracy using the order summary report. IV. This audit will be ongoing. The results will be taken to Performance Improvement Committee monthly for 6 months and re-education will be provided as needed.</p>	

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	<p>A physician's telephone order, dated 4/13/16, indicated an order for Lasix (diuretic) 20 milligrams (mg) by mouth every day times 2 days for edema, and K-Dur (potassium supplement) 10 milliequivalents by mouth every day times 2 days.</p> <p>An "Order Summary Report", dated April 14, 2016, indicated an end date for the K-Dur was 4/16/16, and the Lasix had no end date listed.</p> <p>The Medication Administration Records (MARs) indicated the Lasix had been given every day from April 14, 2016 through July 14, 2016.</p> <p>On 7/14/16 at 8:38 a.m., LPN #1 was observed as she administered Lasix 20 milligrams by mouth to Resident #167.</p> <p>A "Patient Nursing Evaluation", dated 6/17/16, at 10:32 p.m., indicated no edema present.</p> <p>There was no other documentation in the progress notes that indicated the edema had been monitored.</p> <p>A Physician's Telephone Order, dated 7/14/16, indicated: "BMP (Basic Metabolic Profile) today dx (diagnosis) HTN (high blood pressure), BP (blood</p>			

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	<p>pressure) sitting and standing today, record in PCC (Point Click Care-electronic records). Weigh Patient."</p> <p>During an interview, on 7/14/16 at 8:39 a.m., LPN #1 indicated this resident's medications come from another pharmacy, and they haven't been sending the Lasix, so they had to get it from their pharmacy.</p> <p>Progress notes, dated 7/14/16, at 6:18 p.m., indicated: "Received lab results with Potassium level of 3.3 (normal is 3.5-5). Notified [Nurse Practitioner's name] who ordered 10 meq (millequivalents) of potassium PO daily as supplement. Resident has order for Lasix daily due to bilateral edema of lower extremities."</p> <p>During an interview, on 7/15/16 at 10:17 a.m., Unit Manager #2 indicated Resident #167 gets her medications from another pharmacy. She said they had tried to update the Lasix order when the facility was transitioning from paper to computer, you can go in and modify the order, someone tried to update the order and they didn't do it correctly. The order was supposed to be for the two days, then updated to daily on May 24th. There was an electronic order through the facility's pharmacy, but there was no actual written</p>			

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	<p>order that she saw. If it is a verbal order, then it would have been updated to reflect the new order. They educated nurses with the computers system and data entry. Unit Manager #2 indicated she would like to say the current recaps are the ones to go by, but can't say for sure they won't make an error. Also, when an order is obtained, they can type it in as a verbal order and not write it on the telephone orders sheet, or if it is on the telephone orders, they can type it in the system as a telephone order. She said their pharmacy would not have sent the Lasix unless there was an order for it.</p> <p>During an interview, on 7/18/16 at 11:16 a.m., the Director of Nursing Services (DNS) indicated the nurse was supposed to carry the entire order over for the Lasix 20 milligrams; the resident had been on the Lasix, it was effective, and was supposed to be continued. She indicated that the documentation for edema should be documented in the progress notes.</p> <p>A care plan, dated 5/2/16, indicated "[Resident #167] has HTN/CAD (high blood pressure/coronary artery disease): at risk for edema. Goal: [Resident #167] will remain free from s/sx (signs or symptoms) of hypertension through the review date. Interventions: Avoid taking the blood pressure reading after physical</p>			

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	<p>activity or emotion[al] distress. Compression stocking as ordered to reduce lower extremity edema. Encourage to elevate feet as tolerated. Monitor for and document any edema. Notify MD. Monitor/document abnormalities for urinary output. Report significant changes to the MD. Monitor/document/report to MD PRN (as needed) any s/sx of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea). Monitor/record medication side effects. Report to MD as necessary."</p> <p>A Policy and Procedure for "Physician Orders" was provided by the DHS on 7/18/16 at 3:00 p.m. The policy included, but was not limited to, "Physician's orders are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe...Medication Orders: 2. Obtain Medication orders that specify: a. Name of Medication b. Strength of medication, where indicated c. Dosage d. Time or frequency of administration e. Route of administration f. Quantity or duration (length) of therapy...13. Record the order on the physician order sheet/telephone order sheet if it is a verbal order, and on</p>			

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F 0333 SS=E Bldg. 00	<p>the Medication Administration Record (MAR) or Treatment Administration Record (TAR)...Stop Orders. 21. Stop medication orders automatically [stop] after the indicated number of doses or duration of the drug therapy to be given. 25. Discontinue medication orders that do not specify duration or number of doses automatically...27. Write orders correctly: a. Be sure all components of the order are present...f. If transcribing onto an order sheet when placing the order with the pharmacy, double check the order to validate that there are no transcription errors...."</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, record review, and interview the facility failed to ensure one resident's medication regimen was free from significant medication errors for 1 of 8 residents in that a diuretic was given</p>	F 0333	I. The Facility failed to ensure that medication regimen was free from significant med errors. All residents have the potential to be affected by the Facilities deficient practice. All charts were audited by the UMs using the order	08/09/2016

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	<p>without a physician's order. This affected 1 of 6 residents reviewed for unnecessary medications. (Resident #167)</p> <p>Findings include:</p> <p>Resident #167's record was reviewed on 7/13/16 at 1:17 p.m. Physician's recapitulation orders, dated July 2016, indicated Resident #167 had diagnoses that included, but were not limited to, Alzheimer's disease, hypothyroidism, atherosclerotic heart disease, osteoarthritis, high blood pressure, and gastro-esophageal reflux disease.</p> <p>A Quarterly Minimum Data Set assessment, dated 6/1/16, indicated Resident #167 had severe impairment in cognitive skills for daily decision making, required stand by assist with walking, and received a diuretic 7 times in the last 7 days.</p> <p>A physician's telephone order, dated 4/13/16, indicated an order for Lasix (diuretic) 20 milligrams (mg) by mouth every day times 2 days for edema, and K-Dur (potassium supplement) 10 milliequivalents by mouth every day times 2 days.</p> <p>An "Order Summary Report", dated April 14, 2016, indicated an end date for the</p>		<p>summary report on 8/2/16. II. No other residents were identified to be affected by the practice. The affected resident's medication was reviewed by her MD and was found to be appropriate for the resident. The medication order was given to continue the Lasix as well as new orders for Potassium and labs for monitoring. All licensed staff were re-educated on the policy regarding Physician orders, Reordering, changing, and discontinuing orders as well as Medication Regimen Review. Re-education will be provided as needed. III. Chart checks are to be performed by night shift daily and verified weekly by Unit manager/designees. All orders are reviewed by IDT in clinical meeting and audited for accuracy and began on 7/26/16. IV. The results of the audits will be brought to Performance Improvement committee by the DNS for 6 months. The committee will determine if compliance has been met.</p>		

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	<p>K-Dur was 4/16/16, and the Lasix had no end date listed.</p> <p>May 3, 2016 Physician's recapitulation orders indicated: "Lasix Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for two days." Start date 4/14/16.</p> <p>June 1, 2016 physician's recapitulation orders indicated: "Lasix 20 mg (Furosemide) Give 1 tablet by mouth one time a day for two days." Start date 5/25/16.</p> <p>July 1, 2016 physician's recapitulation orders indicated: "Lasix 20 mg (Furosemide) Give 1 tablet by mouth one time a day for two days." Start date 5/25/16.</p> <p>On 7/14/16 at 8:38 a.m., LPN #1 was observed as she administered Lasix 20 milligrams by mouth to Resident #167.</p> <p>The Medication Administration Records (MARs) indicated the Lasix had been given every day from April 14, 2016 through July 14, 2016.</p> <p>During an interview, on 7/14/16 at 8:39 a.m., LPN #1 indicated this resident's medications come from another pharmacy, and they haven't been sending</p>			

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	<p>the Lasix, so they had to get it from their (facility's) pharmacy.</p> <p>During an interview, on 7/15/16 at 10:17 a.m., Unit Manager #2 indicated Resident #167 gets her medications from another pharmacy. She said they had tried to update the Lasix order when the facility was transitioning from paper to computer, you can go in and modify the order, someone tried to update the order and they didn't do it correctly. The order was supposed to be for the two days, then updated to daily on May 24th. There was an electronic order through the facility's pharmacy, but there was no actual written order that she saw. If it is a verbal order, then it would have been updated to reflect the new order. They educated nurses with the computers system and data entry. Unit Manager #2 indicated she would like to say the current recaps are the ones to go by, but can't say for sure they won't make an error. Also, when an order is obtained, they can type it in as a verbal order and not write it on the telephone orders sheet, or if it is on the telephone orders, they can type it in the system as a telephone order. She said their pharmacy would not have sent the Lasix unless there was an order for it.</p> <p>During an interview, on 7/18/16 at 11:16 a.m., the Director of Nursing Services</p>				

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	<p>(DNS) indicated the nurse was supposed to carry the entire order over for the Lasix 20 milligrams; the resident had been on the Lasix, it was effective, and was supposed to be continued.</p> <p>A Policy and Procedure for "Physician Orders" was provided by the DHS on 7/18/16 at 3:00 p.m. The policy included, but was not limited to, "Physician's orders are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe...Medication Orders: 2. Obtain Medication orders that specify: a. Name of Medication b. Strength of medication, where indicated c. Dosage d. Time or frequency of administration e. Route of administration f. Quantity or duration (length) of therapy...13. Record the order on the physician order sheet/telephone order sheet if it is a verbal order, and on the Medication Administration Record (MAR) or Treatment Administration Record (TAR)...Stop Orders. 21. Stop medication orders automatically [stop] after the indicated number of doses or duration of the drug therapy to be given. 25. Discontinue medication orders that do not specify duration or number of doses automatically...27. Write orders correctly: a. Be sure all components of the order are present...f. If transcribing onto an order sheet when placing the</p>			

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F 0356 SS=D Bldg. 00	<p>order with the pharmacy, double check the order to validate that there are no transcription errors...."</p> <p>3.1-25(b)(9)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to</p>			

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	<p>exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based observation and interview, the facility failed to ensure that nurse staffing was posted daily for 11 days. This had the potential to affect all 136 residents residing in the facility and all visitors.</p> <p>Finding include:</p> <p>During initial tour of the facility on 7/11/16 at 9:47 a.m., the nurse staff posting indicated the date was 6/30/16, the total hours for CNA's were 292. hours, LPN's were 124.0 hours and RN's were 60.5 hours. The posting did not indicate the resident census. Interview with the Assistant Director Of Nursing Services (ADNS) indicated it was the responsibility of the Staffing Coordinator to post the nurse staffing and the facility did not currently have a Staff Coordinator. The ADNS updated the nurse staff posting at this time. The new daily staffing indicated the date was 7/11/16, the total hours of CNA's were 284.0 hours, LPN'S were 120 hours and RN's were 44.0 hours, the posting did not indicate the resident census.</p> <p>3.1-13(a)</p>	F 0356	<p>I. The Facility failed to ensure that nurse staffing was posted and reflected direct care hours in adjunct with census. The facility feels that the posting error was inaccurate and the daily posting of hours had inadvertently be removed by either a confused resident or disgruntled staff. The facility has appointed the ED or designee as the responsible party in ensuring this update is posted daily and added a second posting at the front desk of the facility as a backup. This will be changed each morning by DNS or designee. The daily posting of hours will be audited by the ED . Results will be taken to Performance Improvement committee by the ED or designee</p>	08/09/2016

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

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