

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155703	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE VILLAGE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 CHURCH AVE JASPER, IN 47546
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 28, 29, 30, 31, 2014</p> <p>Facility number: 003240 Provider number: 155703</p> <p>Survey team: Amy Wininger, RN, TC Dorothy Watts, RN Sylvia Martin, RN</p> <p>Census bed type: SNF: 25 Residential: 36 Total: 61</p> <p>Census payor type: Medicare: 9 Other: 52 Total: 61</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2</p> <p>Quality review completed on August 7, 2014 by Jodi Meyer, RN</p>	F000000	<p>This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
F000314	483.25(c)			

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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SS=D	<p>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, interview, and record review, the facility failed to ensure care was provided, in that, Resident #4 was admitted with a bruise and callous to the right heel and complete pressure relief was not provided for 1 of 1 resident who met the criteria for review of pressure. This deficient practice resulted in Resident #4 experiencing an unstageable pressure wound to the right heel. (Resident #4)</p> <p>Findings include:</p> <p>On 07/28/14 at 5:30 A.M., Resident #4 was observed lying in bed with closed eyes.</p> <p>During an interview on 07/28/14 at 7:24 A.M., the DON (Director of Nursing) indicated Resident #4 had a vascular</p>	F000314	<p>F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES I. Resident #4 presented to the facility with a discolored area on the right heel and was placed on a turn and reposition program on admission which included paying special attention to the heels. He is currently using a "heelzup" device to provide pressure relief. II. All residents deemed at high risk for pressure areas are placed on a turn and repositioning program, which includes pressure relief for the heels. In addition, specific orders have been included to indicate the need to float heels on all residents currently in-house deemed at high risk for skin breakdown. III. The systemic change includes: ·An option has been added to the computerized nursing order system to choose "Float Heels" in addition to the "Turn and Reposition" option to further clarify the interventions being</p>	08/30/2014			

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	<p>wound to the right heel. The DON further indicated, at that time, Resident #4 was admitted on 04/15/14 without skin issues, and developed multiple fluid filled blisters on the bilateral lower extremities related to PVD (Peripheral Vascular Disease) the day after admission from the hospital. The DON then stated, "...started as a vascularization problem, but when the blister on the right heel ruptured, it left an ulcer... it had a pressure component..."</p> <p>During an interview on 07/29/14 at 9:00 A.M., LPN #5 indicated Resident #4 had been admitted to the hospital the previous evening with a diagnosis of pneumonia.</p> <p>The clinical record of Resident #4 was reviewed on 07/30/14 at 11:54 A.M. The record indicated Resident #4 was admitted to the facility on 04/15/14 with diagnoses including, but not limited to, peripheral vascular disease, compression fractures of the thoracic spine, pneumonia, increasing debility, and prostate cancer with metastasis.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 04/22/14 indicated Resident #4 experienced no cognitive impairment, required the extensive assistance of one staff for bed mobility, was at risk to develop pressure ulcers and</p>		<p>used.</p> <ul style="list-style-type: none"> ·All residents are reviewed upon admission, quarterly, and with significant change to evaluate the resident's risk for skinbreakdown. Residents deemed at risk are provided pressure relief for the heels if appropriate. ·All new admissions will be reviewed Monday-Friday at the daily clinical meeting for initiation of appropriate pressure reduction interventions based on their risk status. <p>Nursing staff have been provided education on the importance to include positioning interventions upon admission for those residents deemed at risk for skin breakdown. This education includes the new nursing order in the computerized nursing order system. The education will be provided for all newly hired nursing staff. IV. The DON or designee, will completea QA tool on 5 residents daily (including weekends) x 30 days , then 5 residents weekly times 5 months, then 5 residents monthly x 6 months to total 12 months of monitoring to monitor for the presence of /completion of the interventions being used for the high risk resident, specifically for the presence of heels being floated. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 3 months and then quarterly</p>				

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	<p>experienced no pressure ulcers.</p> <p>The MDS dated 07/15/14 indicated Resident #4 was at risk to develop pressure ulcers and experienced no pressure ulcers.</p> <p>The Admission Nursing Assessment dated 04/15/14 indicated Resident #4 was observed to have a 2 cm (centimeter) X 1 cm bruise to the right medial heel and a 4 cm X 4 cm callous to the right heel upon admission.</p> <p>An Admission Skin At Risk Assessment dated 04/15/14 indicated Resident #4 was "...at risk for the development of pressure ulcers...care plan initiated..."</p> <p>A Skin Integrity Care Plan dated 04/15/14 included the following interventions: "Conduct a systematic skin inspection weekly. Pay particular attention to the boney prominences, encourage physical activity, mobility, and range of motion to maximal potential, in house barrier cream, report any signs of skin breakdown (sore, tender, red, or broken areas, reposition q (every) 2 hours and prn (as needed), update Md (Doctor) prn, use pressure reduction mattress for pressure reduction when resident is in bed" The Care Plan lacked any interventions to provide complete</p>		<p>thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Compliance date: 08/30/14</p>				

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	<p>pressure relief to the right heel of Resident #4.</p> <p>A Nursing progress note date 04/16/14 at 1:13 P.M. indicated, "Resident noted to having ...edema to BLE (Bilateral Lower Extremities). Bruise found on admission to right heel has fluid filled blister on top of bruise. Blister measures 8 cm (centimeters) X 5 cm...N.O. (New Orders) heel protectors immediately...elevate feet..." The progress note lacked any documentation related to providing complete pressure relief to the right heel.</p> <p>A Nursing progress note dated 04/18/14 at 4:43 P.M. indicated, " (Name of physician) in facility to see resident...called the blisters 'traction blisters' from the hospital...result of the edema...edema is a result of resident having low protein and albumin levels..."</p> <p>A Physician Progress Note dated 04/18/14 indicated, "...patient has had more edema...has blisters on his feet...keeping him off of his feet right now because of the blisters and swelling..."</p> <p>The April 2014 TAR (Treatment Administration Record) included, but was not limited to, an entry dated</p>			

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	<p>04/16/14 of, "...elevate feet...". The TAR lacked any documentation related to providing complete pressure relief to the right heel of Resident #4 from 04/15/14 through 04/17/14.</p> <p>The April 2014 TAR included, but was not limited to, an entry dated 04/17/14 of, "...heel lift boots at all times except during transfers..."</p> <p>A Wound Care Center Record dated 05/09/14 indicated Resident #4 experienced a pressure wound to the right posterior heel. The record further indicated the wound measured, "...3.5 cm length X 6.2 cm width X obscured depth...SDTI (Suspected Deep Tissue Injury), full thickness..."</p> <p>A Wound Care Center Record dated 07/24/14 indicated right heel wound of Resident #4 measured 4.0 cm X 6.2 cm X 0.2 cm with 25% yellow slough and 75% granulation tissue.</p> <p>During an interview on 07/30/14 at 2:37 P.M., the DON indicated Resident #4 was identified as being a high risk to develop pressure upon admission. The DON stated, at that time, the physician had indicated the right heel wound was, "...some sort of traction injury related to positioning himself in the bed..."</p>						

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	<p>During an interview on 07/30/14 at 3:00 P.M., the UM (Unit Manager) #1 indicated no interventions for complete pressure relief to the right heel had been initiated for Resident #4 until 04/17/14.</p> <p>During an interview on 07/31/14 at 9:00 A.M., LPN #5 indicated Resident #4 had returned to the facility.</p> <p>During an interview on 07/31/14 at 12:30 P.M., the DON indicated Resident #4 was admitted to the facility on 04/15/14 from the hospital with a bruise and callous to the right heel. The DON further indicated, at that time, the bruise was not identified as a suspected deep tissue injury because it may have been covered by the callous. The DON then indicated, the pressure relief intervention implemented upon admission to the facility was to reposition Resident #4 every 2 hours and as needed. The DON stated, at that time, "It is in our policy, to float the heels during repositioning, I would expect the staff to have floated his heels as a nursing measure..." The DON then indicated no documentation could be provided to indicate the right heel of Resident #4 had been floated between the admission to the facility on 04/15/14 and 04/17/14.</p>			

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	<p>During an observation on 07/31/14 at 3:30 P.M. a full thickness, round wound was observed on the right posterior heel of Resident #4. During an interview, at that time, UM #1 indicated, the wound had not been measured since the return of Resident #4 from the hospital on 07/30/14. During an interview, at that time, the DON indicated the wound had not changed much since the previous week's assessment.</p> <p>The Policy and Procedure for Pressure provided by the HFA (Health Facilities Administrator) on 07/31/14 at 1:30 P.M. indicated, "...Introduction: ...The most commonly affected sites are...heels...Remember, a pressure ulcer can develop in 1-4 hours...Risk interventions...7. Utilize measures to reduce pressure on heels...Pressure Ulcer Stages: Suspected Deep Tissue Injury: Purple...localized area of discolored intact skin...Skin At Risk Assessment Tool and Skin Inspection Tool...Positioning the resident to minimize pressure over the bony prominences(sic) and shearing forces over the heels..."</p> <p>3.1-40(a)(1)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective safety interventions, supervision, and/or adequate assistance for ambulating in that, a gait belt was not used when ambulating a resident identified at a high risk for experiencing falls for 1 of 4 residents who met the criteria for review of falls and one resident randomly observed who needed transfer assistance. (Resident #1, Resident #73)</p> <p>Findings include:</p> <p>1. During an observation on 7/29/14 at 2:37 P.M., Resident #1 was observed in her room sitting in her wheelchair with her call light on the floor.</p> <p>The clinical record of Resident #1 was reviewed on 7/28/14 at 3:38 P.M. The record indicated Resident #1 was admitted on 11/1/13 with diagnoses including, but not limited to, Parkinson's, dementia with behavioral disturbances,</p>	F000323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES I. Resident #73 was not harmed by the lack of using a gait belt for a transfer. Resident #1 did experience a fall while being ambulated without a gait belt, however no injury was noted from that incident and it is unknown as to whether a gait belt would have entirely eliminated the fall incident. Both residents have a gait belt used when ambulating and for transfer assistance. II. All current residents deemed at high risk for falls have been reviewed and care plans updated to include gait belt use as an intervention as appropriate for each individual. III. The systemic change includes: ·CNA assignment sheets have been updated to indicate which residents are to be transferred/ambulated with the use of a gaitbelt. ·Charge nurses will randomly observe ambulation and/or transfers of residents on their unit throughout their shift to monitor compliance. ·All residents will be reviewed on admission and upon change of	08/30/2014

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	<p>and neurocognitive disorder.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 7/2/14 indicated Resident #1 was cognitive intact and required a walker and the assistance of one person with balance during walking.</p> <p>An Admission Fall Risk Assessment dated 6/30/14 1:54 P.M. indicated a score of 10 or higher represented a high risk for falls. Resident #1 scored 12 on the assessment, documenting Resident #1 at high risk for falls. Resident #1's balance and gait were identified as "Jerking or Unstable When Making Turns"</p> <p>A Care plan for falls read as follows: "...start date 6/30/14... Resident at risk for falling R/T HX of falls and daily psychotic drug use ...7/16/14 Staff education provided to use gait belt when ambulating resident..."</p> <p>Nurse's Progress Notes dated 7/15/14 at 1:10 P.M. read as follows: "Resident was ambulating with walker out of the dining room with CNA et (and) walker. Resident bumped wall with walker causing resident to lose her balance et fall. ...Staff educated on using gait belt at all times when ambulating resident..."</p> <p>2. During a separate, unrelated</p>		<p>condition in mobility status for the need for gait belt use or discontinuation of gait belt use as indicated. This review will take place Monday-Friday at the daily clinical meeting.</p> <p>Nursing staff have been provided education on the facility policy on gait belts. In addition, education has been provided on location of information (care plan and CNA work sheet) indicating which residents have been deemed to likely benefit from the use of a gait belt. Charge nurses have been offered education regarding observing ambulation and/or transfers of residents on their unit throughout their shift to monitor for compliance of the use of gait belts and intervene as needed.</p> <p>The education will be provided for all newly hired nursing staff. IV. The DON or designee will complete a QA tool monitoring the ambulation/transfer of 5 residents who have been deemed to benefit from the use of a gait belt, daily (including weekends) for 30 days, then weekly x 5 months then monthly x 6 months to equal 12 months of monitoring. This audit will include accuracy of the CNA assignment sheet. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as</p>				

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	<p>observation of Resident #73 on 7/28/14 at 8:06 A.M., Resident #73 was transferred from his recliner to his wheelchair by CNA #2 and CNA #3. CNA #2 and CNA #3 assisted Resident #73 by reaching under his arms and using the back of his pants waist to raise him out of his recliner and place him in the wheelchair. Resident #73 was then taken into the bathroom and assisted from the wheelchair to the commode. At that time, both CNA #2 and CNA #3 were observed wearing gait belts around their waists but did not use them to assist Resident #73 during the transfers to his wheelchair from his recliner or from his wheelchair to the commode.</p> <p>During an interview on 7/29/14 at 10:04 A.M., CNA #2 indicated that all residents who required assistance with transfers and walking needed to wear a gait belt during transfers and walking.</p> <p>The Policy and Procedure for Gait Belts for Transfers was provided by the Health Care Administrator on 7/31/14 at 1:30 P.M., and read as follows, "...Standard: Gaits Belts are provided to assist staff to safely transfer or ambulate residents..."</p> <p>3.1-45(a)(2)</p>		needed, if compliance is below 100%. V. Compliance date: 8/30/14				

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	This plan of correction is to serve as Brookside Village's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brookside Village or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
R000300	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation, interview, and record review the facility failed to return and/or dispose of expired medications in a timely manner for 1 of 1 medication storage rooms reviewed on the residential unit in that injectable medications either	R000300	R 300 410 IAC 16.2-5-6(c) (4)Pharmaceutical Services - Deficiency I. Resident #2R and #4R medications were disposed of properly at the time of discovery. II. All medication storage rooms and areas have been audited and no other expired or medications lacking	08/30/2014

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	<p>were lacking open dates and/or stored past acceptable use by dates following opening were stored in a refrigerator. (Resident #2R, Resident #4R)</p> <p>Findings Include:</p> <p>1. On 7/31/14 at 11: A.M., an observation of the medication storage room for the residential unit was completed. During the observation the following multi use injection vials were found stored in the refrigerator.</p> <p>a. Humalog insulin for Resident #4R. The vial and box contained no open date, and a delivery date of 6/20/14. .</p> <p>b. Humalog insulin for Resident #2R. The vial and box contained no open date, and a delivery dated of 5/30/14.</p> <p>c. Lantus with for Resident #2R. The box had an open date of 6/7/14.</p> <p>d. Aplisol (TB testing solution). The vial and box contained no open date and no marked delivery date.</p> <p>e. Influenza Virus Vaccine with an open date of 10/12 and an expiration date of June 2014.</p> <p>LPN #4 indicated when a vial of multi</p>		<p>open dates and/or stored past acceptable use by dates were found. III. The systemic change includes that the night shift nurse has been assigned to audit for dates/expiration dates of injectable medications routinely on Monday, Wednesday and Friday nights. In addition, licensed nurses have been instructed to review all injectable medication for open dates and expiration date prior to administration of the medication. Nursing staff have received education on the need to date all injectable medications to return and/or dispose of expired injectable medications. This education includes the auditing system for night shift nurses and the review of open dates and expiration dates prior to administration of injectable medications. This education will also be provided upon hire of licensed nurses.IV. The DON or designee will complete a QA audit tool daily, including weekends, for 30 days, then weekly x 3 months, then monthly for an additional 8 months to equal 12 months of monitoring of compliance with proper dating and disposal of injectable medications protocols. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as</p>		

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	<p>use injectable medication is opened it should be marked with an open date. She further indicated , the most injectable medications were good for 30 days following the open date.</p> <p>The Health Facility Administrator provided a policy titled "DRUG STORAGE" on 7/31/14 at 2:15 P.M. The policy included on page D-3 " ...4. Discontinued and expired medications should be removed from medication refrigerators promptly. Return drugs or destroy them according to pharmacy and facility policies...</p> <p>...7. Insulin and PPD (TB) vaccine and other multi-dose vials requiring refrigeration need to be dated when opened. All vials should be discarded within 28 days of the open date."</p>		needed, if compliance is below 100%. V. Compliance date: 8/30/14		

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R000356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. <p>Based on interview, and record review, the facility failed to ensure emergency files were complete, in that, the emergency files of 2 residents were not complete in a sample of 5, who met the criteria for review of emergency files.</p>	R000356	R 356 410 IAC 16.2-5-8. 1(i) (1-8)Clinical Records - Noncompliance I. The Emergency File records of #20R and #6R have been updated to include the appropriate information. II. The Emergency File records of all current residents have been reviewed	08/30/2014

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	<p>(Residents #20, Resident #6)</p> <p>Findings include:</p> <p>1. Resident #20's clinical record was reviewed on 7/30/14 at 4:10 P.M. Resident #20 was admitted to the facility on 7/24/14 with diagnoses including, but not limited to, fracture, hypertension, and depression.</p> <p>The emergency file for Resident #20 was reviewed at 4:00 P.M. on 7/30/13. The emergency information included only a picture of the resident. The resident's file lacked the room number, allergies, the physician's name and phone number. There was no date of birth, hospital preference, name and phone number of a legally authorized representative, names and numbers of family members or others to be contacted in the event of emergency or death, and no copy of advance directives.</p> <p>2. Resident #6's clinical record was reviewed on 7/30/14 at 4:10 P.M. Resident #6 was admitted to the facility on 7/7/12 with diagnoses including, but not limited to, DM type 2, and hypertension.</p> <p>The emergency file for Resident #6 was reviewed at 4:00 P.M. on 7/7/12. The</p>		<p>and all others were found to have all of the appropriate information. III. The systemic change includes that the night shift nurse is now assigned to audit the emergency binder for all appropriate emergency file information for new admissions every day (7 days a week). A checklist has been devised to be utilized by the night shift nurse for the appropriate information which should be included. Nurses and Medical Records staff have received education on items to be included in the emergency file of all residents on the residential unit. This education includes a review of the new checklist that will be utilized. This education will be completed upon hire of new Medical Record or licensed nursing staff. IV. The DON or designee will complete a QA audit tool monitoring the staff compliance of completion of emergency binder information for new admissions daily (including weekends) for 30 days, weekly for 5 months and then monthly for an additional 6 months for a total of 12months of monitoring. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Compliance date:</p>		

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	<p>emergency information included a picture of the resident, room number, the physician's name and phone number, date of birth, hospital preference, name and phone number of a legally authorized representative, names and numbers of family members or others to be contacted in the event of emergency or death, and a copy of the resident's advance directives. The file lacked a list of allergies, and no wrist band was in the file.</p> <p>The Assisted Living Facility's Policy and Procedure for the Medical Records Disaster Binder was reviewed on 7/31/14 at 2:15 P.M., the policy read as follows: "The Medical Records Director is responsible for the upkeep of the Disaster Binder in order for nursing to be prepared to evacuate the building in the event of an emergency. The binder will include the resident's face sheet and identification bracelet. The Medical Records Director will update this binder by adding new admissions and removing discharged residents. In the event of an emergency, this binder(s) will evacuate the building along with the residents in order to properly identify and account for each resident."</p> <p>During an interview on 7/30/14 at 4:15 P.M., LPN #3 indicated there should have been a completed Emergency File</p>		8/30/14	

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	for each resident in the facility. LPN #3 further indicated the emergency file was lacing the required information.				