

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/25/2013
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 20, 21, 22, and 25, 2013</p> <p>Facility number: 000414 Provider number: 155436 AIM number: 100288550</p> <p>Survey team: Caitlyn Doyle, RN-TC Regina Sanders, RN Jennifer Redlin, RN Heather Hite, RN</p> <p>Census bed type: SNF/NF: 25 Total: 25</p> <p>Census payor type: Medicare: 1 Medicaid: 18 Other: 6 Total: 25</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 1, 2013, by Janelyn Kulik, RN.</p>	F000000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal laws. Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on December 20, 2013</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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F000279 SS=D	<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, record review, and interview, the facility failed to develop care plans for residents, related to aspirin usage and risks for bruising, for 2 of 15 residents reviewed for care plans. (Residents #3 and #15)</p> <p>Findings include:</p> <p>1. Resident #15 was observed on 11/20/13 at 1:35 p.m. The resident had a purple colored area on the back of his left hand.</p>	F000279	F279 It is the standard of this facility to develop a care plan that includes measurable objectives to meet the resident's medical, nursing, mental and psychosocial needs, including side effects of medications that are ordered by the physician, such as frequent bruising. 1. What corrective action will be done by the facility? The care plan for resident #15 and #3 has been updated as needed for bruising related to aspirin use. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All	12/13/2013	

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	<p>Resident #15's record was reviewed on 11/21/13 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia, Parkinson's Disease, hypotension, and diabetes.</p> <p>A physician's order, dated 08/06/13, indicated an order for aspirin 81 mg, one tablet daily.</p> <p>The Weekly Skin Assessment sheets, indicated the following: 9/16/13- "...Old bruises to BUE (bilateral upper extremity) continuing to fade..." 10/07/13- "...Bruise (L) (left) hand 1 cm (centimeter) x (by) 2 cm purple..." 10/14/13- "...Bruise left hand 1 cm x 1.5 cm diffuse..." 10/22/13-, "...Bruise (L) hand fading..."</p> <p>An Assessment of Other Skin Abnormalities, dated 11/03/13, indicated the resident had bruise between the second and third fingers.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the aspirin usage and risk for bruises.</p> <p>During an interview on 11/22/13 at 7:44 a.m., the MDS Coordinator</p>		<p>care plans for residents receiving routine aspirin therapy and other medications known to cause increased bruising have been reviewed and updated by the interdisciplinary team. Updates include interventions to monitor weekly skin assessments and labs as ordered by the physician. However, if the DON or designee finds that a resident receiving medication with a side effect of bruising does not have a care plan in place, she will bring that issue to the next scheduled interdisciplinary morning management meeting for review and development of an appropriate care plan with interventions recommended by the IDT team. Once that care plan has been developed and is in place, the DON will review the facility policy regarding the development of pertinent care plans for residents on medications with side effects, such as bruising, with the staff involved.</p> <p>3. What measures will be put into place to ensure that this practice does not recur? All new resident orders will be reviewed at least 5 times a week by the Director of Nursing or designee. The results of this review will be shared with the Interdisciplinary Team during the morning management meeting that also occurs at least 5 times a week. Any identified issues will be addressed as indicated in question #2. The team will then</p>		

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	<p>indicated the resident did not have a care plan for the aspirin use or risk for bruising. She indicated the resident has had several bruises.</p> <p>A facility policy, dated 06/04, titled, "Skin Conditions, Adverse", received from the DoN (Director of Nursing) as current, indicated, "...8. The resident's care plan will be revised to include the skin problem, approaches, and goals for care. Response to the plan of care will be documented in the weekly summary..."</p>		<p>write a care plan for the ordered medication, including any interventions that are a result of the interdisciplinary team discussion at the morning meeting. The care plan will be placed on that resident's chart at that time and the CNA assignment sheet will be updated, if necessary. The interdisciplinary team will continue to monitor care plans during the weekly care plan meeting and as physician orders change. Care plans are also reviewed and updated quarterly with the MDS process and when changes occur that affect resident care. In addition, random care plan audits of those residents receiving medications with known bruising risks will be completed weekly for the next 90 days to ensure care plans reflect current medication use. Results of the audits will be forwarded to the Administrator. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of the care plan audits will be forwarded to the monthly QA&amp;A committee for further review for 90 days and until 100% compliance is obtained. The QA&amp;A committee will then determine the need for further monitoring. However, even when the QA Committee no longer wants to review this issue, the DON/designee's review of all new orders for residents and the</p>		

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	<p>2. During an observation on 11/20/13 at 3:13 p.m., Resident #3 was observed to have a purple colored area on the back of his right hand. During an interview at the time of the observation, Resident #3 indicated he was unaware of what caused the purple discoloration.</p> <p>During an observation on 11/22/13 at 3:14 p.m., a light purple discolored area was observed on the resident's left forearm and on the resident's left hand in the knuckle area.</p> <p>Resident #3's record was reviewed on 11/21/13 at 11:51 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and diabetes.</p> <p>Review of the November 2013 Physician's Recapitulation Orders indicated an order for Aspirin 81 milligrams (mg), one tablet daily, originally ordered on 7/17/13.</p> <p>The Nurses Notes, indicated the following: 9/9/13- "...Bruising noted to right hand...measures approx</p>		processes outlined previously will continue on an ongoing basis. Date of Compliance: 12/13/2013		

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	<p>(approximately) 8cm (centimeters) x (by) 6cm, dark purple in color, and 1.5cm x 1.5cm from previous IV (intravenous) site, res (resident) states, purple in color..."</p> <p>10/6/13-"...Dr. (doctor, name) notified of bruises, left hand 1 1/4" (inches) x 3/4", dark purple between thumb and first finger, 1 1/2" x 3/4" right forearm dark purple..."</p> <p>The Weekly Skin Evaluation sheets, dated 10/13/13 through 11/17/13, indicated the resident had bruises to the left hand, left forearm, and right hand and they were fading.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the aspirin usage and risk for bruises.</p> <p>Interview with the MDS Coordinator on 11/25/13 at 10:04 a.m., indicated there was no care plan in place for the resident related to aspirin usage and risk for bruises. The MDS Coordinator indicated there should have been a care plan in place.</p> <p>3.1-35(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure residents' care plans and Physician's orders were followed, related to insulin dosages and laboratory tests, for 2 of 22 residents reviewed for Physician's orders and care plans. (Residents #3 and #15)</p> <p>Findings include:</p> <p>1. Resident #15's record was reviewed on 11/21/13 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia, Parkinson's Disease, and diabetes.</p> <p>A care plan, dated 09/25/13, indicated the resident was a diabetic. The interventions included, "...Administer my medications as ordered..."</p> <p>A Physician's order, dated 08/27/13, indicated an order for Novolog insulin to be given after the resident's blood sugar was checked (glucometer check) and the amount of the insulin would be per the glucometer check (sliding scale). The order indicated</p>	F000282	<p>F 282 It is the policy of this facility that services are provided or arranged by qualified persons in accordance with each resident's written plan of care including following physician orders for insulin dosages and laboratory tests. 1. What corrective action will be done by the facility? There are currently two residents remaining on this insulin administration plan for sliding scale insulin who are residing in the facility. Resident #15 nor resident # 3 has experienced no ill-effects from the concern identified regarding insulin coverage. The nurse who failed to follow the individual order for insulin administration has received disciplinary action as well as re-education. No further errors have been identified. Lab was not drawn as resident was in hospital. Upon return all orders will be reviewed with Doctor and addressed as needed. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All insulin dependent residents on a sliding scale have the potential to be affected; however no other issues have</p>	12/01/2013	

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	<p>the following: Blood sugar 111-150= one unit of insulin Blood sugar 151-200= two units of insulin Blood sugar 201-250= four units of insulin Blood sugar 251-300= six units of insulin Blood sugar 301-350= eight units of insulin If the blood sugar was over 300= notify the physician</p> <p>The October 2013 Medication Administration Record (MAR) included the following blood sugars and doses of insulin given: 8 p.m. on 10/10/13- blood sugar was 169 and no insulin was given 6 a.m. on 10/16/13- blood sugar 124 and no insulin was given 6 a.m. on 10/19/13- blood sugar 119 and no insulin was given 8 p.m. on 10/24/13- blood sugar was 132 and two units of insulin was given 8 p.m. on 10/27/13- blood sugar was 146 and no insulin was given 6 a.m. on 10/29/13- blood sugar 117 and no insulin was given</p> <p>The November 2013 MAR indicated on 11/13/13 at 6 a.m., the resident's blood sugar was 136 and no insulin was given.</p>		<p>been identified regarding this issue. All insulin administration records for these diabetic residents were reviewed by the Director of Nursing and no other residents were affected. In the future the DON identifies a concern related to the administration of insulin or the completion of a laboratory test as ordered by the physician, she will make sure that the physician is notified as quickly as possible and any resulting orders are followed through. Once the resident situation is taken care of, the DON will re-train the nurse(s) involved in the facility procedure for following physician orders, the administration of insulin, and the completion of laboratory tests. She will also follow through with progressive disciplinary action as indicated by the situation. Residents returning from hospital will have all orders reviewed and addressed with physician. 3. What measures will be put into place to ensure that this practice does not recur? A Review of the Medication Administration Records for sliding scale insulin administration will be conducted by the Director of Nursing or Designee. These audits will be completed five days per week for four weeks, three days per week for four weeks and then weekly for four weeks. Audit results will be forwarded to the Administrator. Any identified</p>		

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	<p>During an interview on 11/21/14 at 3:19 p.m., the MDS Coordinator, indicated the resident had not received the correct doses of insulin on the above dates.</p> <p>2. Resident #3's record was reviewed on 11/21/13 at 11:51 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, anxiety, and mood disorder.</p> <p>Review of the Physician Recapitulation Orders dated 11/2013, indicated lab orders for CMP (electrolytes), lipids, depakote level, and HgbA1C (a laboratory test to assess blood sugar) every six months in January and July.</p> <p>There was lack of documentation in the record to indicate the depakote level had been completed for July</p>		<p>concerns will be addressed as outlined in question #2. Residents returning from hospital will have all orders reviewed and addressed with physician. DON or designee will review orders within 48 hours and address any concerns noted. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing audit results will be reviewed at the monthly QA&amp;A committee meeting for 90 days and until 100% compliance is obtained. Further audits will be completed as recommended by the QA&amp;A committee.. Date of Compliance: 12/01/2013</p>		

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	<p>2013.</p> <p>Review of the lab requisiton form dated 7/30/13 lacked documentation to indicate the depakote level had been completed.</p> <p>Review of the current plan of care, updated on 10/23/13, indicated the resident had a diagnoses of mood disorder and took psychotropic medications. The Nursing approaches included, obtain labs as ordered</p> <p>Interview with the Director of Nursing (DoN) on 11/25/13 at 3:50 p.m. indicated the depakote level was not completed as ordered. The DoN indicated the facility had not ordered the depakote level on the lab requisiton for 7/30/13.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p><b>483.25</b> PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment and services, related to the monitoring and assessment of a bruise for 1 of 3 residents reviewed for skin conditions. (Resident #15)</p> <p>Findings include:</p> <p>Resident #15 was observed on 11/20/13 at 1:35 p.m. The resident had a purple colored area on the back of his left hand.</p> <p>Resident #15's record was reviewed on 11/21/13 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia, Parkinson's Disease, and diabetes.</p> <p>During an interview on 11/22/13 at 7:34 a.m., the DoN indicated when bruising was found, the Nurse should initiate an Assessment of Other Skin Abnormalities form.</p>	F000309	<p>F309 It is the policy of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including monitoring and assessment of skin conditions such as bruises. 1. What corrective action will be done by the facility? The Director of Nursing presented an inservice on December 4, 2013 for nursing staff to review the facility policy regarding assessment, monitoring, and documentation of weekly skin assessments, episodic care plans, non-pressure skin sheets and showersheets. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? On 12/13/2013 head to toe skin assessments have been completed for all residents by the Director of Nursing and MDS coordinator. No new skin concerns were identified. If the DON becomes aware of a skin issue that has not been</p>	12/10/2013	

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	<p>During an interview on 11/22/13 at 7:34 a.m., the DoN indicated the last skin assessment had been completed on 11/11/13 and the skin assessment had not indicated the resident had a discoloration on the back of his left hand.</p> <p>During an interview on 11/22/13 at 7:50 a.m., the DoN indicated she was unable to find an Assessment of Other Skin Abnormalities form for the purple area on the back of the resident's left hand. She indicated there was no documentation in the Nurses' Notes to indicate the resident had an area on the back of his left hand.</p> <p>The DoN, completed a Weekly Skin Assessment form, dated 11/22/13 and indicated the resident had a discoloration on the back of the left hand which measured 1.5 cm x 1.5 cm, she indicated the discoloration could possibly be a bruise or a skin discoloration.</p> <p>A facility policy, dated 06/04, titled, "Skin Assessments", received from the DoN as current, indicated, "...Head to toe assessments will be done weekly...2. Documentation of these skin assessments will be</p>		<p>assessed, monitored, or documented as per facility policy, she will re-train the nursing staff involved regarding the facility policy and will make sure that an updated assessment and documentation of the status of the skin issue is done. She will also render progressive disciplinary action for any issue that shows a pattern of continued noncompliance. The DON will also bring the situation to the next scheduled interdisciplinary morning meeting for review by the interdisciplinary team to make sure that interventions are current and appropriate to meet the resident's changing needs. Any new interventions will be added to the resident's care plan and the CNA assignment sheet. The DON will note the changes on the 24 hour report so that oncoming shifts can be made aware. 3. What measures will be put into place to ensure that this practice does not recur? The DON will continue to review the focus charting, 24 hour report, new physician orders, and incident reports at least 5 days a week as part of her morning routine. She will bring them to the interdisciplinary morning management meeting for further review and recommendation as indicated in question #2. In addition, the DON or designee will complete a random audit three times a week for 30 days and then weekly for 60 days to</p>				

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	<p>completed, using the 'Weekly Head-To-Toe Skin Assessment' form..."</p> <p>A facility policy, dated 06/04, titled, "Skin Conditions, Adverse", received from the DoN as current, indicated, "...2. Skin observations are made daily during the performance of bathing and dressing residents...3. Skin assessments are done weekly by a licensed nurse who have any adverse skin conditions. The results are recorded on the appropriate skin report form...4. Nursing assistants are responsible for promptly notifying the charge nurse of all observations; for example:...b. bruises...h. skin discolorations...8. The resident's care plan will be revised to include the skin problem, approaches, and goals for care. Response to the plan of care will be documented in the weekly summary..."</p> <p>3.1-37(a)</p>		<p>ensure completion of weekly skin assessments, non-pressure skin form completion when indicated and episodic care plans when indicated. As per policy, the showersheets that are completed by the CNAs during each resident's shower/bath will also be reviewed by the DON. Results of these reviews will be brought to the interdisciplinary team at the morning management meeting as indicated previously. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing will bring the results of the audits to the monthly QA&amp;A meeting for 90 days where the Committee will review and monitor progress for that time period. After the 90 days has finished, the QA&amp;A Committee may decide to stop the requirement for the written audits and reporting of those results if 100% compliance has been reported. However, the DON's review of the focus charting, 24 hour report, new physician orders, incident reports and shower sheets will continue on an ongoing basis. Date of Compliance: 12/10/2013</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure residents' were free from unnecessary medications and failed to ensure residents were monitored for medication use, related to incorrect dosages of insulin, laboratory testing, and no prior interventions attempted before the administration of an anti-anxiety medication for 2 of 5 residents reviewed for unnecessary medication. (Residents #3 and #15)</p>	F000329	F329 It is the policy of this facility to ensure that residents are free from unnecessary medications and are monitored for medication use, including correct dosages of insulin, laboratory testing as ordered by the physician, and attempts of non-pharmacological interventions prior to administering anti-anxiety medication. 1. What corrective action will be done by the facility? Resident #15 has experienced no ill-effects from the concern identified regarding insulin coverage. The nurse who	12/13/2013	

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	<p>Findings include:</p> <p>1. Resident #15's record was reviewed on 11/21/13 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia, Parkinson's Disease, and diabetes.</p> <p>A Physician's order, dated 08/27/13, indicated an order for Novolog insulin to be given after the resident's blood sugar was checked (glucometer check) and the amount of the insulin would be per the glucometer check (sliding scale). The order indicated the following:            Blood sugar 111-150= one unit of insulin            Blood sugar 151-200= two units of insulin            Blood sugar 201-250= four units of insulin            Blood sugar 251-300= six units of insulin            Blood sugar 301-350= eight units of insulin            If the blood sugar was over 300= notify the physician</p> <p>The October 2013 Medication Administration Record (MAR) included the following blood sugars and doses of insulin given:            8 p.m. on 10/10/13- blood sugar was 169 and no insulin was given</p>		<p>failed to follow the individual order for insulin administration has received disciplinary action as well as re-education. No further errors have been identified. Resident #3 has an order for lorazepam 0.5mg one tablet every 6 hours as needed for anxiety. The nurses have been inserviced on the importance of attempting and documenting non-pharmacological interventions prior to administering the PRN order. In addition, the nurses were inserviced on use of the antianxiety flow sheets to document their attempts at non-drug interventions. The antianxiety flow sheets have been placed with medication administration records. On November 26, 2013, the lab for the Depakote level was drawn. This lab had been missed previously as the resident was hospitalized when it was due to be drawn. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All insulin dependent residents on a sliding scale have the potential to be affected; however no other issues have been identified regarding this issue. All insulin administration records for these diabetic residents were reviewed by the Director of Nursing and no other residents were affected. Two other residents have orders for PRN</p>		

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	<p>6 a.m. on 10/16/13- blood sugar 124 and no insulin was given 6 a.m. on 10/19/13- blood sugar 119 and no insulin was given 8 p.m. on 10/24/13- blood sugar was 132 and two units of insulin was given 8 p.m. on 10/27/13- blood sugar was 146 and no insulin was given 6 a.m. on 10/29/13- blood sugar 117 and no insulin was given</p> <p>The November 2013 MAR indicated on 11/13/13 at 6 a.m., the resident's blood sugar was 136 and no insulin was given.</p> <p>During an interview on 11/21/14 at 3:19 p.m., the MDS Coordinator, indicated the resident had not received the correct doses of insulin on the above dates.</p>		<p>antianxiety. One resident did receive the PRN medication and documentation was evident on the antianxiety flow sheet demonstrating that interventions were tried prior to medication administration. The other resident has not required the PRN medication. The DON/designee has checked the laboratory orders for each resident to make sure the tests have been completed. There were no other residents found to have missing laboratory tests. 3. What measures will be put into place to ensure that this practice does not recur? The Director of Nursing or designee will audit daily the medication administration record of those residents with PRN psychotropic medications ordered to ensure non-pharmacological interventions have been attempted and documented prior to administering the PRN medication. A Review of the Medication Administration Records for sliding scale insulin administration will be conducted by the Director of Nursing or Designee. These audits will be completed five days per week for four weeks, three days per week for four weeks and then weekly for four weeks. Audit results will be forwarded to the Administrator. Residents returning from hospital will have all orders reviewed and addressed with physician. DON or designee will review orders within 48 hours</p>		

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	<p>2. Resident #3's record was reviewed on 11/21/13 at 11:51 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, anxiety, mood disorder, and diabetes.</p> <p>Review of the November 2013 Physician's Recapitulation Orders indicated an order for Lorazepam (Ativan, an antianxiety medication) 0.5 milligrams (mg), one tablet every 6 hours as needed, originally ordered on 9/8/13.</p> <p>The Medication Administration Record (MAR), dated 11/2013,</p>		<p>and address any concerns noted. If the DON identifies any concern regarding documentation or follow through of physician orders as a result of any of these audits, she will retrain the nurse(s) involved. She will also render disciplinary action for continued noncompliance. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing audit results will be reviewed at the monthly QA &amp; A committee meeting for 90 days and until 100% compliance is obtained. Further audits will be completed as recommended by the QA &amp; A committee. Date of Compliance: 12/13/2013</p>		

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	<p>indicated the resident received the Lorazepam on November 3, 4, 5, 6, 8 (twice), 12, 13, 16, 17, 18, 19, 20, and 21 for anxiety.</p> <p>The MAR, dated 10/2013, indicated the resident received the Lorazepam on October 1 (twice), 6, 7, 14 (twice), 15, 16, 17, 19, 22, 23, 25, 26, 27 (twice), 29, 30, and 31 (twice) for anxiety.</p> <p>There was lack of documentation on the 10/2013 and 11/2013 MAR to indicate the symptoms of the anxiety and any interventions attempted prior to administering the medication.</p> <p>Interview with the Director of Nursing (DoN) on 11/25/13 at 11:00 a.m., indicated there should be an anxiety flow sheet for the Lorazepam that includes interventions attempted prior to administering the medication. She indicated there was no anxiety flow sheet for this resident, but sometimes the nurses document the prior interventions in the Nurses Notes.</p> <p>The Nurses Notes lacked documentation of the symptoms of the anxiety and any interventions attempted prior to administering the medication for November 4, 5, 6, 12, 13, 17, 19, 20, and October 6, 7, 14,</p>			

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	<p>16, 19, 22, 23, 25, 27, 29, and 31.</p> <p>There was lack of documentation in the Behavior Log, for the above dates, to indicate the symptoms of anxiety and any interventions attempted prior to administering the medication.</p> <p>A facility policy, undated, titled, "Psychoactive Drug Monitoring," received from the Nurse Consultant as current, indicated, "...3. Non-pharmacological interventions such as behavior modification or social services and their effects are documented..." and "...Antianxiety/sedative drugs...4. Behavioral monitoring charts or a similar mechanism are used to document the resident's need for and response to drug therapy..."</p> <p>Review of the Physician Recapitulation Orders dated 11/2013, indicated lab orders for CMP (electrolytes), lipids, depakote level, and HgbA1C (a laboratory test to assess blood sugar) every six months in January and July.</p> <p>There was lack of documentation in the record to indicate the depakote level had been completed for July 2013.</p>						

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	<p>Review of the lab requisiton form dated 7/30/13 lacked documentation to indicate the depakote level had been completed.</p> <p>Interview with the DoN on 11/25/13 at 3:50 p.m. indicated the depakote level was not completed as ordered. The DoN indicated the facility had not ordered the depakote level on the lab requisiton for 7/30/13.</p> <p>3.1-48(a)(6)</p>			

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F000516 SS=C	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview the facility failed to secure confidential records for current and former residents. This had the potential to affect 25 residents currently residing in the facility.</p> <p>Findings include:</p> <p>The Medical Records/Minimum Data Set (MDS) office door was observed to be open and the office unattended throughout the survey, including the following times: 11/20/13 at 9:30 a.m. 11/20/13 at 10:05 a.m. 11/20/13 at 10:50 a.m. 11/20/13 at 1:15 p.m. 11/25/13 at 10:09 a.m. 11/25/13 at 11:15 p.m.</p> <p>In an interview with the Medical</p>	F000516	F516 It is the policy of this facility to secure confidential records of residents against loss, destruction, or unauthorized use. 1. What corrective action will be done by the facility? The Maintenance Director replaced the door knob to be self locking as well as a self closure. MDS Coordinator was inserviced on pulling the door shut upon exit whenever she leaves the office where records are stored. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No resident was affected by the deficiency. 3. What measures will be put into place to ensure that this practice does not recur? Maintenance has installed a self closure as well as a self locking door knob on the MDS door to prevent this deficiency. If any manager notes	11/25/2013			

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	<p>Records/MDS Coordinator on 11/25/13 at 11:17 a.m. she indicated the filing cabinets inside the office were not locked. She indicated, "I have never locked them, but my door locks." She further indicated her door had been left open while she was not in the office.</p> <p>3.1-50(d) 3.1-50(e)</p>		<p>that the MDS office is unsecured when the MDS Coordinator is not in it, he/she will close the door to the room at that time and notify the Administrator. The Administrator will address the issue with the MDS Coordinator and reinforce the facility policy that is in place to protect the residents' confidential records. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Administrator will report the status of the security of the MDS Office to the QA&amp;A Committee on a monthly basis for the next 3 months. After that, if the QA&amp;A Committee concurs, the Administrator will only report instances where the residents' records are left unsecured in the MDS office as they occur for further recommendations by the Committee members. Date of Compliance: 11/25/2013</p>		