

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2013
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NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN 46310
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 22, 23, 24, 25, and 26, 2013</p> <p>Facility number: 010823 Provider number: 155667 AIM number: 200236630</p> <p>Survey team: Regina Sanders, RN, TC Shannon Pietraszewski, RN Sharon Ewing, RN Heather Hite, RN</p> <p>Census bed type: SNF: 15 SNF/NF: 34 Total: 49</p> <p>Census Payor type: Medicare: 10 Medicaid: 23 Other: 16 Total: 49</p> <p>There deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 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 law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on August 25, 2013. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</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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F000151 SS=D	<p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>Based on interview and record review, the facility failed to ensure a resident had the opportunity to exercise her rights to make decisions about her care, related to decreasing of a medications without prior discussing the decrease with the resident, for 1 of 10 residents reviewed for unnecessary medications. (Resident #10)</p> <p>Finding include:</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis, non-insulin dependent diabetes, insomnia and anemia.</p> <p>An Annual Minimum Data Set Assessment, dated 06/07/13, indicated the resident was cognitively intact.</p>	F000151	<p>F151 It is the policy of this facility to ensure all residents have the right to exercise his or her rights as a resident of the facility and citizen or resident of the United States; and to ensure the resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. <u>I. Specific Corrective Actions:</u> The decrease in medication (Trazadone) was immediately discussed with resident #10. <u>II. Identification and correction of others:</u> All residents have the potential to be affected by a decrease in medication being made without having it discussed with the resident first. All resident charts were reviewed for proper resident notification of any change in dosage of medication. <u>III. Systemic Changes:</u> All nurses will be educated regarding resident notification regarding any medication changes, if appropriate, prior to the change being made. In-services will occur prior to August 25, 2013.</p>	08/25/2013	

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	<p>A pharmacological note to Resident #10's physician, dated 6/12/13, indicated a recommendation of a gradual dose reduction on Trazadone (anti-depressant) 25 mg at bedtime. The resident's physician checked to continue routine order and administer only six nights per week and the Nurse was to chart any differences in the resident's sleep pattern on the nights the Trazadone was and was not received.</p> <p>A physician order, dated 6/18/13 at 3:00 p.m., indicated to change the Trazadone 25 mg daily at bedtime to Monday through Saturday and monitor for sleep pattern changes on Sunday.</p> <p>A nursing note, dated 6/25/13 at 3:00 p.m., indicated the decrease in the Trazadone had not been discussed with the resident prior to the Trazadone being decreased.</p> <p>An interview with LPN #3 on 7/25/13 at 9:45 a.m., indicated the recommendation for reduction in the Trazadone should have been discussed with the resident prior to the written order.</p> <p>3.1-3(n)(2)</p>		<p>[Attachment: InserviceNursesPOC8.2013] <u>IV. Monitoring:</u> The DON, ADON and/or designee will review daily (Monday through Friday) any new physician orders for medication changes. She will check that the resident, if appropriate, was notified prior to the change being made. The daily audits will continue for one month, then weekly random audits of 6 charts will occur for two months, then monthly random audits of 6 charts will continue for four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: 24 Hour Condition Report]</p>				

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician when a resident's pain was not relieved after pain medication was administered for 1 of 10</p>	F000157	F157 It is the policy of this facility to ensure the Physician is notified of changes in a resident's condition, refusal of treatments, and follow up after a medication change. <u>I. Specific Corrective</u>	08/25/2013

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	<p>resident's reviewed for unnecessary medications. (Resident #10)</p> <p>Findings include:</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis, non-insulin dependent diabetes, insomnia and anemia.</p> <p>A nursing note, dated 7/19/13 at 8:00 p.m., indicated Tramadol (pain medication) 50 mg (milligrams) was given for back pain. The resident had indicated the Tramadol did not work. The record lacked documentation to indicate the resident's physician had been notified the pain medication was ineffective.</p> <p>A nursing note, dated 7/21/13 at 9:30 p.m., indicated the resident continued to complain of back pain after Tylenol and Tramadol and Aspercream (topical agent) was administered. The record lacked documentation to indicate the resident's physician had been notified the pain medication was ineffective.</p> <p>A nursing note, dated 7/23/13 at 4:20 p.m., indicated the resident requested</p>		<p>Actions: The physician was immediately notified of the failure to follow policy regarding notification that resident #10's pain was not addressed by the 50 mg of Tramadol on 7/19/13. II. Identification and correction of others: All residents have the potential to be affected by Physician notification not being completed as per policy. Resident charts were reviewed for proper Physician notification regarding a change in medication being ineffective. III. Systemic Changes: All nurses will be re-educated regarding the Physician Notification Policy prior to August 25, 2013. [Attachment: InserviceNursesPOC8.2013]</p> <p>IV. Monitoring: The DON, ADON and/or designee will review daily (Monday through Friday) any new physician orders. Any resident with a medication change will have their chart audited for proper Physician Notification if the medication change was ineffective. The daily audits will continue for one month, then weekly random audits of 6 charts will occur for two months, then monthly random audits of 6 charts will continue for four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing</p>		

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	<p>pain medication for her back. Lidocaine cream (topical agent) was attempted with little relief. The record lacked documentation to indicate the resident's physician had been notified the pain medication was ineffective.</p> <p>During an interview on 7/25/13 at 4:00 p.m., Resident #10 indicated her pain medication of Tramadol (pain medication) was ordered to be given every 8 hours starting today, and she was glad to know she can have it as needed in between scheduled doses.</p> <p>An interview with LPN #4 on 7/24/13 at 10:30 a.m., indicated if the Tramadol was ineffective, the physician should have been contacted. LPN #4 indicated the pain had intensified over the past couple of months.</p> <p>A policy for Physician and Family Notification of Condition Change, dated 08/31/19, provided by the DoN (Director of Nursing) on 7/26/13 at 11:06 a.m., indicated the facility would immediately inform the physician when there was a need to alter a treatment significantly and when there were a significant change in the resident's physical, mental, or psychosocial status. The licensed nurse who attempted to notify the</p>		compliance. [Attachment: 24 Hour Condition Report]				

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	<p>resident/family/physician was responsible for documenting actual notification in the nurses' notes.</p> <p>3.1-5(a)(3)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	F225 It is the policy of this facility	08/25/2013			

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	<p>interview, the facility failed to immediately notify the Indiana State Department of Health (ISDH) of allegations of abuse for 2 or 3 residents reviewed for abuse allegations. (Resident #8 and #10)</p> <p>Findings include:</p> <p>1. During an interview with Resident #8 on 7/22/13 at 2:10 p.m., the resident indicated she had been treated roughly by staff occasionally. The resident indicated when the staff get her up with the lift, they would kick the lift with their feet and it would jerk the lift which caused her pain in her arms and left shoulder. The Administrator was informed on 7/23/13 at 1:45 p.m. of the allegation.</p> <p>Resident #8's clinical record was reviewed on 7/24/13 at 12:35 p.m. Resident #8's diagnoses included, but were not limited to, agitation, anxiety, diabetes mellitus, degenerative joint disease, hypertension, congestive heart failure, and ischemic heart disease.</p> <p>A social service note, dated 5/1/13, indicated the resident was cognitively intact.</p> <p>An interview with the SSD (Social Service Director), Administrator, and</p>		<p>to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). I. Specific Corrective Actions: Immediately upon learning that she had misunderstood the surveyor regarding these being abuse allegations, the Administrator promptly reported both allegations (which had immediately been investigated and felt to be unsubstantiated) to ISDH and all other required officials. II. Identification and correction of others: There were no other alleged violations of mistreatment, neglect or abuse. III. Systemic Changes: The Administrator, DON and Director of Social Services will review, and sign that they have reviewed, the policy regarding the reporting of alleged violations of mistreatment, neglect or abuse. [Attachment: Signed Abuse and Other Reportable Incidents P&P] IV. Monitoring: All future allegations, for the next seven months, will be reviewed to ensure they are reported per policy regarding timeliness of the report to ISDH. The time of the allegation and time reported to</p>		

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	<p>DoN (Director of Nursing), on 7/24/13 at 2:50 p.m., indicated the allegation had not been reported to ISDH.</p> <p>2. An interview with Resident #10 on 7/23/13 at 9:30 a.m., indicated a staff member had been rude to her. The resident indicated approximately two months ago, a staff person flipped on the light and indicated loudly that it was time to get up to her former room-mate. The resident indicated when she asked the staff member what she was doing and what was going on, the staff member indicated rudely that she was doing her job. The Administrator was informed of the allegation on 7/23/13 at 1:45 p.m.</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis, non-insulin dependent diabetes, insomnia and anemia.</p> <p>A social service note, dated 4/4/13, indicated the resident was cognitively intact.</p> <p>An interview with the SSD (Social Service Director), Administrator, and DoN on 7/24/13 at 2:50 p.m., indicated the allegation had not been</p>		<p>ISDH will be reported monthly at the facility's QAPI Meetings for any allegations occurring that month. [Attachment: Reportable Incident Investigation Worksheet]</p>		

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	reported to ISDH. 3.1-28(c)				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's abuse policy, related to reporting the allegation to the Indiana State Department of Health (ISDH) for 2 of 3 allegations reviewed for abuse allegations. (Resident #8 and #10)</p> <p>Findings include:</p> <p>1. An interview with Resident #8 on 7/22/13 at 2:10 p.m., indicated she had been treated roughly by staff occasionally. The resident indicated when the staff get her up with the lift, they would kick the lift with their feet and it would jerk the lift which caused her pain in her arms and left shoulder. The Administrator was informed of the allegation on 7/23/13 at 1:45 p.m.</p> <p>Resident #8's clinical record was reviewed on 7/24/13 at 12:35 p.m. Resident #8's diagnoses included, but were not limited to, agitation, anxiety, diabetes mellitus, degenerative joint disease, hypertension, congestive heart failure, and ischemic heart</p>	F000226	<p>F226 It is the policy of this facility to ensure it has written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. I. Specific Corrective Actions: Immediately upon learning that she had misunderstood the surveyor regarding these being abuse allegations, the Administrator promptly reported both allegations (which had immediately been investigated and felt to be unsubstantiated) to ISDH and all other required officials. II. Identification and correction of others: There were no other alleged violations of mistreatment, neglect or abuse. III. Systemic Changes: The Administrator, DON and Director of Social Services will review, and sign that they have reviewed the policy regarding the reporting of alleged violations of mistreatment, neglect or abuse. [Attachment: Signed Abuse and Other Reportable Incidents P&P] IV. Monitoring: All future allegations, for the next seven months, will be reviewed to ensure they are reported per</p>	08/25/2013	

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	<p>disease.</p> <p>A social service note, dated 5/1/13, indicated the resident was cognitively intact.</p> <p>An interview with the SSD (Social Service Director), Administrator, and DoN (Director of Nursing) on 7/24/13 at 2:50 p.m., indicated the allegation had not been reported to ISDH.</p> <p>2. An interview with Resident #10 on 7/23/13 at 9:30 a.m., indicated a staff member had been rude to her. The resident indicated approximately two months ago, a staff person flipped on the light and indicated loudly that it was time to get up to her former room-mate. The resident indicated when she asked the staff member what she was doing and what was going on, the staff member indicated rudely that she was doing her job. The Administrator was informed of the allegation on 7/23/13 at 1:45 p.m.</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis, non-insulin dependent diabetes, insomnia and anemia.</p>		<p>policy regarding timeliness of the report to ISDH. The time of the allegation and time reported to ISDH will be reported monthly at the facility's QAPI Meetings for any allegations occurring that month. [Attachment: Reportable Incident Investigation Worksheet]</p>		

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	<p>A social service note, dated 4/4/13, indicated the resident was cognitively intact.</p> <p>An interview with the SSD (Social Service Director), Administrator, and DoN on 7/24/13 at 2:50 p.m., indicated the allegation was not reported to ISDH.</p> <p>An Abuse and Other Reportable Incidents policy, dated 2/20/13, was provided by the Administrator on 7/24/13 at 10:50 a.m. The policy indicated "...Facilities are required by law to immediately ("immediately" means as soon as possible, but not ought to exceed 24 hours after discovery of the incident) report incidents to the Long Term Care Division..."</p> <p>3.1-28(a)</p>			

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to promote care for residents in a manner which enhances each residents' dignity and respect, related to addressing the residents by using the words, "Honey, Sweet Heart, and/or Darling" during meal times, not assisting residents with meals while others at the table had began to eat, and talking about residents in front of other residents during meal times, for 2 of 3 Dining Rooms, which had the potential to affect 18 residents who consume their meals in the Skilled Dining Room and 17 residents who consume their meals in the Shepherd's Unit Dining Room. (Residents #7, #15, #42, and #46)</p> <p>Findings include:</p> <p>1. During the observation of the lunch meal on the Shepherd's Unit on 07/22/13 from 12 p.m. through 12:44 p.m., RN #1 was assisting with the delivery of the meal to the residents. RN #1 had addressed the residents</p>	F000241	<p>F241 It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. I. Specific Corrective Actions: The staff involved in addressing residents inappropriately, not assisting the residents with their meal while their tablemates had begun eating, and talking about residents in front of other residents were all immediately counseled regarding these issues. II. Identification and correction of others: All residents have the potential to be affected by being addressed inappropriately, not being assisted with their meal at the same time their tablemates are eating, and being talked about by staff in front of other residents. Staff was immediately educated about these issues and again at the All Staff Meetings held August 8, 2013 at 6:30 AM, 1:15 PM, 2:15 PM, and 3:30 PM. III. Systemic Changes: Any staff that did not attend a meeting on August 8, 2013 will have the material reviewed with them by</p>	08/25/2013			

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	<p>using the words, "Honey" twice, "Darling" three times, and "Young Lady" once.</p> <p>During an observation of the breakfast meal on the Shepherd's Unit on 07/23/13 from 8:13 a.m. through 8:35 a.m., LPN # 2 addressed a resident by using the word, "Sweet Heart". CNA #3 and CNA #6, which were sitting at two different tables, then discussed Resident #42's status and ability to eat with other residents present at the tables.</p> <p>2. During a dining observation on 7/22/13 at 11:35 a.m. on the Skilled Unit, three residents were already seated for lunch. Staff assisted the remaining residents intermittently to the dining tables between 11:45 a.m. and 12:07 p.m. A covered tray cart was brought to the dining room at 12:06 p.m.</p> <p>An observation at 12:08 p.m. indicated one staff member called Resident #15 "honey." Drinks were passed starting at 12:10 pm. Observation at 12:15 p.m. indicated a second staff member called Resident</p>		<p>August 25, 2013. [InservicePOC8.2013] IV. Monitoring: The nurses will do daily audits at all three meals in All Dining Rooms to ensure residents are being addressed properly, all residents at a table are eating at the same time, and residents are not being discussed by staff in front of other residents. After one month audits will be done weekly for three months, then every other week at random meals for three more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Quality of Life/Dignity Review]</p>		

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	<p>#46 "honey."</p> <p>The observation indicated, 18 residents were present and four staff were passing out food from the cart and giving setup assistance as needed. Resident #15 sat with food in front of her for 15 minutes while the rest of the residents at the table ate or were assisted before staff asked Resident #15 if she was going to eat. Resident #15 shook her head indicating, "no." No alternative food was offered at this time. At 12:38 p.m., nursing staff started to assist Resident #15 who refused the meat, and liked only the potatoes and roll.</p> <p>3. An observation on 7/25/13 at 8:28 a.m. in the main dining room where 17 residents were seated for breakfast on the Shepherd's Unit, CNA #3 was observed washing her hands at the Dining Room sink. Another unidentified staff person asked C.N.A. #3 " Do you want to get [Resident #7's first name]?" C.N.A #3 replied while continuing to wash her hands, "No, not really but I will." C.N.A. # 3 proceeded to[Resident #7's] room and provided care for her.</p> <p>On 7/26/13 9:20 A.M. DoN (Director of Nursing) was interviewed and indicated, "Conversation in the dining</p>				

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	room should be person centered." 3.1-3(t)			

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to inform a resident in advance of a roommate change for 1 out of 2 residents who met the criteria for notification of change. (Resident #51)</p> <p>Findings include:</p> <p>During an interview with Resident #51, whose assessment for cognitive status indicated high cognitive functioning, on 07/22/2013 at 2:38 p.m., she indicated she had a roommate change in the last nine months, "after my previous roommate passed away." She further indicated she was not notified before a new roommate (Resident #6) was moved into her room. She stated, "We don't know what the reason was. We were eating dinner and the roommates were switched."</p> <p>During an interview with the Social Services Director on 7/25/13 at 3:55 p.m. regarding documentation of notification of a roommate change for Resident #51, she indicated no written documentation was found</p>	F000247	<p>F247 It is the policy of this facility to ensure a resident receives notice before the resident's room or roommate in the facility is changed. I. Specific Corrective Actions: Social Service apologized to Resident #51 and assured her she was on the waiting list for a private room. II. Identification and correction of others: All residents have the potential to be affected by lack of notification of a roommate change. All room changes, involving a new roommate moving in, were reviewed for documentation of proper notifications. III. Systemic Changes: Social Service was re-educated regarding notification to a resident prior to a room or roommate change. [InserviceSSPOC8.2013] IV. Monitoring: Social Services will provide a list of roommate changes to Medical Records weekly for the next two months. Medical Records will audit for proper notifications. It will then decrease to monthly for five more months with six random audits a month, if applicable. Any concerns identified will be documented on a quality assurance tracking log and</p>	08/25/2013	

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	<p>indicating Resident #51 and/or family were notified of a roommate change since admission.</p> <p>Resident #51's record was reviewed on 7/25/13 at 1:40 p.m. and indicated the resident was admitted from home on 3/6/13 into a semi-private room. A Social Services note dated 3/11/13 indicated a meeting was held with Resident #51 and her husband and the resident's husband said, "things were going well until she got a roommate." A request for a private room was made at this time. The record lacked documentation of notification to indicate any change in roommate status since admission.</p> <p>Resident #6's record was reviewed on 7/25/13 at 2:00 p.m. and indicated a Social Service note dated 5/3/13, "Res (resident) offered another room location & she accepted. Res pleased with new location. She now has a semi-private with windows." Resident #6 was moved into semi-private room with Resident #51.</p> <p>A facility policy, dated 09/99, titled, "Room to Room Transfer" and received from the Social Services Director as current, indicated, "...A roommate will be informed of any new transfer into his/her room. Such</p>		corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance.				

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	<p>information will include why the transfer is being made and any information that will assist the roommate in accepting his or her new roommate...documentation of a room transfer is recorded in the resident's record..."</p> <p>3.1-3(v)(2)</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 follow physician's orders and care plans, related to laboratory testing, blood pressures, weekly weights, and medication for 3 of 10 residents reviewed for unnecessary medications. (Residents #8, #10, and #15)</p> <p>Findings include:</p> <p>1. Resident #15's record was reviewed 7/24/13 at 10:13 a.m. The resident's diagnoses included, but were not limited to, dementia, dementia with delusions, organic psychosis, diabetes, CVA, aphasia, cva, seizures, depression, DVT, hypothyroidism, HTN (high blood pressure), GERD (reflux), hyperlipidemia, recurrent UTI's (urinary tract infection).</p> <p>The resident's care plan, dated 07/23/13, indicated the resident had a diagnosis of diabetes mellitus and hyperlipidemia (high cholesterol). The interventions included, to</p>	F000282	<p>F282 It is the policy of this facility to provide or arrange services by qualified persons in accordance with each resident's written plan of care. I. Specific Corrective Actions: The physician(s) was notified of laboratory testing that did not get done, blood pressures not done, weekly weights not done, and a dose of UTI-Stat not administered. All lab tests ordered and done as appropriate, blood pressures done, weights obtained and dose of UTI-Stat administered. II. Identification and correction of others: All residents have the potential to be affected by physician's orders and care plans not followed in relation to laboratory testing, blood pressures, weekly weights, and medications. All physician orders and care plans were reviewed to ensure all were followed per policy. III. Systemic Changes: Nursing staff will be educated on following physician orders and care plans related to laboratory testing, blood pressures, weekly weights and medication prior to August 25, 2013. [Attachment: InserviceNursesPOC8.2013] IV. Monitoring: The DON, ADON</p>	08/25/2013	

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	<p>complete laboratory testing as ordered by the resident's physician and notify the physician and the resident's family of the results.</p> <p>The Physician's Recapitulation Orders, dated 05/13, indicated orders for HgbA1C (test for blood sugars) and lipid panels (test for cholesterol) to be completed every three months.</p> <p>The last HgbA1c and lipid panel laboratory tests in the resident's record were dated 03/04/13. There was a lack of documentation to indicate the laboratory tests had been completed in June (every three months) as ordered by the physician.</p> <p>During an interview on 7/25/13 at 7:53 a.m., the DoN (Director of Nursing) indicated she could not find anything to indicated the HgbA1c and lipid panel had been completed in June. She indicated she had called laboratory company and was informed they did not have an order for laboratory tests to be drawn.</p> <p>2. Resident #8's clinical record was reviewed on 7/24/13 at 12:35 p.m. Resident #8's diagnoses included, but were not limited to, agitation, anxiety, diabetes mellitus, degenerative joint disease, hypertension, congestive heart failure, and ischemic heart</p>		<p>and/or designee will audit compliance by reviewing six random charts per week for two months regarding following physician orders and care plans related to laboratory testing, blood pressures, weekly weights and medication. The audits will then decrease to monthly for four more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: 24 Hour Condition Report]</p>				

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	<p>disease.</p> <p>Review of the Physician Recapitulations orders for April, May, June, and July 2013, indicated an order dated 9/11/12, for UTI (urinary tract infection) stat liquid (supplement to help prevent UTI's) 30 mls (milliliters) to be given by mouth twice a day to prevent UTI's; an order dated 10/21/10, to check blood pressures weekly on Monday; an order dated 2/5/13, for orthostatic blood pressure (lying and standing); and an order dated 10/21/13, for weekly weights.</p> <p>Review of the May, 2013 MAR (Medication Administration Record) indicated weekly weights were not completed during the weeks of 5/20/13 and 5/27/13.</p> <p>Review of the June, 2013 MAR indicated weekly weights were not completed after June 1, 2013.</p> <p>Review of the July, 2013 MAR indicated the weekly blood pressure was not completed during the week of 7/22/13. The monthly orthostatic (lying and sitting) blood pressure was not completed the on 7/1/13 as scheduled. The weekly weight was not completed the week of 7/15/13. The MAR lacked documentation to</p>						

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	<p>indicated the UTI-Stat had been administered to the resident during the month of July 2013.</p> <p>An interview with LPN #4 on 7/25/13 at 3:30 P.M., indicated the UTI-stat liquid was to be documented in the MAR when given, and weights and blood pressures were to be done weekly, and orthostatic blood pressure was to be done monthly.</p> <p>3. Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis, non-insulin dependent diabetes, insomnia and anemia.</p> <p>Review of the June and July Physician Recapitulation orders, indicated an order dated 5/6/13 for a CMP [sic] (should be CBC) w/ diff and BMP (complete blood count and electrolytes) to be done monthly.</p> <p>Review of the June and July MARs (Medication Administration Record) and TAR (Treatment Administration Record) did not indicate if the labs had been completed.</p> <p>Review of the Lab Section of the clinical record, indicated the last CBC</p>						

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	<p>and BMP had been completed on 5/20/13.</p> <p>An interview with the DoN (Director of Nursing) on 7/24/13 at 12:20 p.m., indicated the labs were not completed. The DoN indicated she had contacted the company who provided lab services and the company indicated their records showed the lab tests had been discontinued.</p> <p>An interview with the DoN on 7/24/13 at 2:00 p.m., indicated she was not able to locate the original written physicians order for the lab in the resident's clinical record.</p> <p>There was lack of documentation to indicate if the facility followed up/notified the lab company when the ordered specimens was due to be drawn.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to assess a resident for the effectiveness of pain medications and failed to ensure a resident's pain was controlled, related to back pain for 1 of 1 resident's reviewed for pain. (Resident #10)</p> <p>Findings include:</p> <p>On 7/23/13 at 9:00 a.m., Resident #10 was observed pacing in her room from her chair to the bathroom.</p> <p>On 7/24/13 at 9:20 a.m., Resident #10 was observed ambulating/pacing down the hall with her walker. During this time, Resident #10 was interviewed and indicated she continued to have back pain and felt she would "have to live with it".</p> <p>On 7/25/13 at 4:00 p.m., Resident #10 was observed in the hallway walking slowly and appeared to be in discomfort. During this time,</p>	F000309	<p>F309 It is the policy of this facility to ensure residents are provided the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. I. Specific Corrective Actions: Any nurses responsible for monitoring of Resident #10's pain were re-educated regarding monitoring the level of pain and the effectiveness of the pain medication; and ensuring Resident #10's pain was controlled. II. Identification and correction of others: All residents have the potential to be affected by pain assessments not completed per policy. All residents on pain medication were reviewed for proper assessment and management of pain. III. Systemic Changes: A new Pain Management Policy was created. Nursing staff will be re-educated on the pain evaluation procedure and proper follow through regarding pain management by August 25,</p>	08/25/2013	

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	<p>Resident #10 was interviewed and indicated her pain medication of Tramadol (pain medication) was ordered to be given every 8 hours starting today, and she was glad to know she can have it as needed in between scheduled doses. The resident indicated the Tylenol was not helping her pain. The resident indicated she had not used the heating pad due to the risk of burns. The resident indicated she could not sit for long periods of time because it caused discomfort.</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, macular degenerative disease, CVA (stroke), spinal stimulation, Osteoarthritis, non insulin dependent diabetes, hiatal hernia, frequent urinary tract infections, and anemia.</p> <p>The initial plan of care, undated, indicated Resident #10 was at risk for pain due to osteoarthritis. The interventions indicated to administer pain medication as ordered, assess for pain level using 1-10 scale prior to the administration of the medication and within one hour after the administration of the medication, notify the physician if the pain</p>		<p>2013. [Attachment: Pain Management Policy & InserviceNursesPOC8.2013] IV. Monitoring: The DON, ADON and/or designee will randomly audit six charts per week of residents on pain medication for three months. It will then decrease to every other week for four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: 24 Hour Condition Report]</p>		

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	<p>medication was not effective, complete a pain assessment at least quarterly, document pain medication administration, reposition for comfort, and encourage the resident to ask for the pain medication at first sign of unrelieved pain.</p> <p>A nursing note dated, 7/11/13 at 7:00 p.m., indicated the resident requested Tylenol at 6:00 p.m. for back pain. "No relief but will continue to monitor." No further monitoring was documented.</p> <p>A nursing note dated, 7/12/13 at 9:10 a.m., indicated the resident complained of back pain, voiced that she was anxious to see the physician but was worried back surgery would be suggested. "No request for pain meds (medications). Will continue to monitor res (resident)." No further documentation regarding the resident's pain was addressed the remainder of the shift.</p> <p>A nursing note, dated 7/12/13 at 6:00 p.m., indicated a new order from the physician for a heating pad for the back pain as needed in the "p.m."</p> <p>There was a lack of documentation to indicate the resident's pain had been monitored until 07/18/13.</p>			

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	<p>A nursing note, dated 7/18/13 at 11:00 p.m., indicated a new order was received for the resident to have Tramadol 50 mg (milligrams) four times a day as needed for pain that was unrelieved by Tylenol. This was seven days after the resident indicated the Tylenol was not helping her pain.</p> <p>An X-ray dated 7/19/13, indicated the resident had a posterior decompression L3-L5 (Lumbar/curvature of the back) and degeneration of the lower lumbar spine.</p> <p>Review of the July, 2013, MAR (Medication administration record) indicated Tylenol was given on 7/18/13 at 10:00 a.m., 7/22/13 at 7:40 a.m. and 7/23/13 at 8:00 a.m., but did not indicate if the Tylenol was effective.</p> <p>A nursing note, dated 7/20/13 at 10:15 p.m., indicated the resident complained of back pain and tylenol was given but ineffective. The Tramadol was given.</p> <p>Review of the July, 2013, MAR did not indicate if the Tramadol was effective.</p>						

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	<p>A nursing note, dated 7/23/13 at 5:00 a.m., indicated the resident continued to complain of back pain, the resident had requested Tylenol, and nursing would continue to monitor. Review of the nursing notes and the July 2013, MAR on 7/23/13, did not indicate if the Tylenol was effective.</p> <p>Review of the July, 2013, MAR (Medication administration record) indicated Tramadol was given on 7/20/13 at 9:00 (illegible for a.m. or p.m.), and 7/23/13 at 3:00 p.m., but did not indicate if the medication was effective.</p> <p>Review of a Pain Evaluation Assessment, dated 7/23/13, indicated the resident had voiced laying and sitting increased her pain. The resident had a diagnosis of lumbar degenerative disc. Pain was internal, chronic and was constant. Present pain was 9 1/2 out of 10 with 10 being the worst. One hour after medication was given, the pain was still an 8. Three hours after the medication, the pain was a 9. Pain at the worst was 10 and the best pain level was 5. The Pain Assessment in Advanced Dementia (PAINAD) scale/section indicated the resident had an occasional moan or groan, low level</p>			

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	<p>speech with a negative or disapproving quality, sad, frightened, frowning, tense, distressed pacing, fidgeting, and distracted. The ADL (Activities of Daily Living) section indicated the resident would participate in activities but would leave early, withdrawal from activities/relationships, and had changes in mood/emotions. Relief of pain indicated "None of the above" which suggested medication, relaxation, frequent position changes, heat, cold, massage, meditation, music, diversional activity and distraction. Medication section indicated Celebrex 200 mg (anti-inflammatory) daily was the scheduled pain medication. PRN (as needed) pain medication indicated acetaminophen (Tylenol) 1000 mg every 6 hours as needed and Tramadol 50 mg three times a day if not relieved with Tramadol. This section indicated the pain medication was not effective, and the resident indicated a small amount of relief was short lived.</p> <p>An interview with LPN #4 on 7/24/13 at 10:30 a.m., indicated if the Tramadol was ineffective, the physician would be contacted. LPN #4 indicated the pain had intensified over the past couple of months.</p>			

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	<p>Interview with the DoN (Director of Nursing) on 7/25/13 at 4:10 p.m., indicated the resident's daughter was informed of the risks of using the heating pad and the heating pad had been discontinued. She indicated she had not thought about other alternatives for pain relief.</p> <p>3.1-37(a)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received a therapeutic diet as ordered by the physician, related to six small meals a day, for 1 of 1 resident reviewed for a therapeutic diet. (Resident #28)</p> <p>Findings include:</p> <p>During an interview on 07/22/13 at 11:47 a.m., Resident # 28 indicated she did not care for the food she was served at the facility.</p> <p>Resident #28's record was reviewed on 07/24/13 at 1:41 p.m. The resident's diagnoses included, but were not limited to gastroparesis (slow emptying of the stomach) and gastroesophageal reflux disease. The resident had been readmitted to the facility from the hospital on 06/22/13.</p>	F000325	<p>F325 It is the policy of this facility to ensure that based on a resident's comprehensive assessment, he/she maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem. I. <u>Specific Corrective Actions:</u> Resident #28's diet card and care plan were immediately updated to indicate six small meals a day as a therapeutic diet and the nurses caring for Resident #28 were instructed to monitor that all six small meals were delivered to the resident. II. <u>Identification and correction of others:</u> All residents have the potential to be affected by failure to ensure a resident receives her/his therapeutic diet as ordered by the physician. All residents on therapeutic diets were reviewed to ensure they receive their therapeutic diet as ordered by</p>	08/25/2013			

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	<p>The hospital History and Physical, dated 6/11/13, indicated the resident had upper abdominal pain with nausea for the past two weeks and had not improved with the interventions attempted and the resident had reported the food had not tasted good for the past five to six weeks.</p> <p>A hospital progress note, dated 06/22/13, indicated the resident was given a diagnosis of diabetic gastroparesis.</p> <p>A Quarterly Minimum Data Set Assessment, dated 05/16/13, indicated the resident's cognition was intact.</p> <p>The Physician's Recapitulation Orders, dated 07/13, indicated a diet order for mechanical soft, no concentrated sweets, no added salt diet with snacks between meals, no fried foods and no whole wheat breads.</p> <p>A, "Nutrition Therapy for Gastroparesis" form, dated 06/20/13 and located with the resident's Medication administration record, indicated, "Your stomach empties very slowly...This can cause bloating, nausea, vomiting, or feeling full after</p>		<p>their physician. III. Systemic Changes: Dietary and Nursing staff will be re-educated on therapeutic diets and a new tracking form to indicate if the resident accepted or refused his/her therapeutic meal by August 25, 2013. [InservicePOC8.2013] IV. Monitoring: The Dietary Manager and/or designee will audit the tracking form in place for every therapeutic diet every day for two months; any missing documentation or discrepancies will be shared with the DON or ADON. It will then decrease to weekly for two months, and then every other week for three months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Scheduled Snack Pass Record]</p>				

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	<p>eating only a small amount of food...Eat frequent meals (4-6 per day). Avoid foods high in fat...Avoid foods high in fiber...Recommended Foods...Milk, Instant breakfast, Milkshakes, Yogurt, Puddings, Custard, Smoothies, Pureed Foods, Soup..."</p> <p>A Registered Dietician's note, dated 06/24/13, indicated, "...will provide snacks between meals to provide 6 small meals, no fired foods, no whole wheat bread..."</p> <p>The Dietary Intake record, dated 07/13, indicated the resident had received one snack from July 1-24, 2013 in the afternoon on July 19, 2013. There was a lack of documentation to indicate the resident had received a snack between meals and at night the rest of the days.</p> <p>An interview on 7/24/13 at 2:34 p.m. , Resident #28 indicated the food was somewhat not good due to her stomach problems. She indicated she would like a better variety. She indicated the alternates like a toasted cheese sandwich, were not very good options for her. She indicated some days she received snacks, but some of the snacks she could not eat. She</p>			

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	<p>indicated no one had spoken to her about the diet she was on. She indicated she had chicken and green beans for lunch today and she told the staff before the food was brought, she could not have beans, but she received the beans anyway. She indicated she sent the beans back and asked for mashed potatoes and was told they were not serving mashed potatoes. She indicated she would like to know what she could have and what she could not have to eat. She indicated she would like to know what would be offered to her. She indicated no one had spoke to her about her diet since she had returned from the hospital. She indicated the physician had informed her she should eat six times a day and have smaller meals. She indicated she does not always get her snacks and had not received a snack yet this afternoon.</p> <p>During an observation on 7/24/13 at 3:09 p.m., CNA #1 was passing snacks on the Skilled Unit. During an interview, she indicated the Shepherd's Unit already passed their snacks.</p> <p>During an observation of the snack cart's cooler, there was a container of yogurt sitting in the cooler with</p>						

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	<p>Resident #28's name written on it.</p> <p>During an interview on 07/24/13 at 3:11 p.m., Resident #28 indicated she had not received an afternoon snack.</p> <p>During an interview on 07/24/13 at 3:12 p.m., CNA #2, who worked on the Shepherd's Unit where Resident #28 resided, indicated all the afternoon snacks had been delivered to the residents.</p> <p>During an observation on 07/25/13 at 10:34 a.m., there was a bowl of nectarines sitting at Resident #28's bedside. Resident #28 indicated they had brought the nectarines in as a snack and she had told them they hurt her stomach, but they left them at the bedside anyway.</p> <p>During an interview on 7/25/13 at 11:06 a.m., the Dietary Manager indicated snacks are delivered at 10 a.m., 2 p.m., and 7 p.m. and the CNA's should document the amount taken of the snack. She indicated no one had spoke to the resident about her diet since the resident's return from the hospital.</p> <p>3.1-46(a)(1)</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 gradual dose reductions were recommended for 1 of 10 residents reviewed for psychotropic medications. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's clinical record was reviewed on 7/24/13 at 12:35 p.m. Resident #8's diagnoses included, but were not limited to, agitation, anxiety,</p>	F000329	F329It is the policy of this facility to ensure each resident's drug regimen is free from unnecessary drugs. It is also the policy of this facility, based on a comprehensive assessment of residents, to 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	08/25/2013			

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	<p>diabetes mellitus, degenerative joint disease, hypertension, congestive heart failure, and ischemic heart disease.</p> <p>A Social Service notes dated 11/7/12 (late entry for 10/26/12), 1/28/13, 2/11/13, 3/19/13, and 5/1/13, indicated the resident was receiving Xanax (anti-anxiety medication) 0.125 mg twice a day, Remeron (anti-depressant) 15 mg at bedtime, Prozac (anti-depressant) 30 mg daily and Risperidone (anti-psychotic) 0.25 mg at 4:00 p.m. The note indicated the resident has had no reported behaviors.</p> <p>A Psych note dated 2/5/13, 2/26/13, 3/19/13, 3/26/13, 4/15/13, 4/25/13, 5/10/13, 6/13/13, and 6/26/13, indicated the resident was seen and there were no changes with medications, mood or behavior issues.</p> <p>Review of the Pharmacy log from 5/9/12 to 6/12/13, there had been no attempt for a gradual dose reduction with the Xanax and with the Prozac.</p> <p>An interview with the DoN on 7/25/13 at 4:00 p.m., indicated she had identified a problem with psychotropic medications being ordered when a</p>		<p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The reason for the IDR request is that we have been doing GDRs per our policy based on resident specific needs. Physch and Pharmacist disagreed with doing further GDRs on this resident due to history. [Attachments: Physch Notes, Pharmacist Notes, Behavioral Assessment Mngt P&P and Timeline] I. Specific Corrective Actions:The resident's medication history was reviewed and pharmacy was contacted to review resident's medications to make recommendations. II. Identification and correction of others:All residents have the potential to be affected by a missed GDR for any psychotropic medication that may be prescribed. All charts of residents on psychotropic medication(s) were reviewed for appropriate GDRs. III. Systemic Changes:All nurses will be educated regarding gradual dose reduction requirements prior to August 25, 2013. [Attachment: InseviceNursesPOC8.2013] IV. Monitoring:Social Services will track all residents on psychotropic medications for required GDRs working in partnership with the consultant pharmacist. The pharmacist will provide monthly updates of residents on psychotropic medication(s) with</p>				

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	<p>resident has behaviors from urinary tract infections and also indicated she was aware of gradual dose reductions not being recommended by the pharmacy or reduced by the physician.</p> <p>3.1-47(a)(6)</p>		<p>date of last GDR indicated on the report. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance.</p>		

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to serve food at the proper temperature, related to food sitting and cooling before staff could assist residents with eating for 3 of 3 residents who required help with meals and 1 of 5 residents who met the criteria for food quality in 1 of 2 dining rooms. (Residents #11, #28, #38, and #44)</p> <p>Findings include:</p> <p>During an interview on 07/22/2013 at 11:48 a.m., Resident #28 indicated the meals served were cold and she would have to ask the staff to warm up her meals for here.</p> <p>During an observation on 07/22/13 at 12 p.m., there were two CNA's delivering the lunch meal to the residents in the Shepherd's Unit Dining Room. At 12:15 p.m. Resident's #11, #38, and #44 received their lunch meal. The food was placed, uncovered in front of the residents on the table. Resident's</p>	F000364	<p>F364 It is the policy of this facility to provide and ensure each resident receives food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at proper temperature. I. Specific Corrective Actions: The facility policy was reviewed with RN #1 and CNAs #3, #5, #6 and #7 regarding timely assistance to residents with their meals so the food is still at the proper temperature when they eat the meal. II. Identification and correction of others: All residents have the potential to be affected by food cooling before the resident is assisted with eating the meal. All residents' sequence of meals were reviewed for appropriate timely assistance immediately upon serving the food. III. Systemic Changes: All nursing staff will be educated regarding Sequence of Meals and timely assistance with meals prior to August 25, 2013. [InservicePOC8.2013] IV. Monitoring: The nurse on duty will monitor that all residents are assisted with their meals immediately upon being served.</p>	08/25/2013			

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	<p>#11, #38, and #44 were unable to eat their meal by themselves. At 12:35 p.m. RN #1 sat and began to assist Resident #44 with his meal, this was 20 minutes after the meal was served to the resident. CNA #5 then sat and assisted Resident #38 with her meal at 12:41 p.m. and at 12:44 p.m., CNA #5 sat to assist Resident #11 with her meal.</p> <p>During an observation of the Shepherd's Unit breakfast meal on 07/23/13 at 8:13 a.m., Residents #11, #38, and #44 breakfast meal was served uncovered, on the table in front of the residents. CNA #6 sat to feed Resident #11 at 8:18 a.m. CNA #3 sat down to feed Resident #38 and CNA #7 sat to feed Resident #44 at 8:30 a.m., then CNA #6 stopped feeding Resident #11, and left the dining room to answer a call light, leaving Resident #11's breakfast uncovered in front of the resident. CNA #6 then returned to the dining room at 8:35 a.m. and again assisted Resident #11 with her breakfast meal.</p> <p>During an observation of the Shepherd's Unit breakfast meal on 07/24/13 at 7:44 a.m. The breakfast meal arrived at 8 a.m. in the food cart. CNA's #3 and #5 began delivering the breakfast trays to the residents at</p>		The DON, ADON and/or designee will review the monitoring tool daily for any deviations from policy. After one month the review will be weekly for three months; then monthly for three months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Quality of Life/Dignity Review]				

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	<p>8:10 a.m. At 8:18 a.m., Residents #11, #38, and #44 received their breakfast meal, at which time a sample tray was also removed from the food cart. At 8:25 a.m., CNA #5 sat to assist Resident #11 with her meal. Residents # 38 and #44 were still sitting at their table with the uncovered breakfast in front of them and no staff were assisting the residents with their meals. Staff sat to assist Residents #38 and #44 with their meal at 8:30 a.m.</p> <p>The test tray was sampled at 8:25 a.m., the scrambled eggs with gravy, oatmeal, and super cereal were sampled as cool to taste.</p> <p>During an observation and interview on 07/24/13 at 8:29 a.m., the Dietary Manager indicated checked the temperature of the test tray, the scrambled eggs and gravy registered at 98.6 degrees, oatmeal at 98.6 degrees and the super cereal at 98.7 degrees. The Dietary Manager indicated the temperatures were not hot enough.</p> <p>A facility policy, undated, and received from the Director of Nursing on 07/25/13 at 9 a.m., titled, "Sequence of Meals/Trays and Tray Cards", indicated, "...Meals and trays</p>			

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	for individuals who need assisted are served together for timely feeding..." 3.1-21(a)(2)				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to have a system to accurately reconcile controlled medications, related to, the</p>	F000431	F 431 It is the policy of this facility to have a system to accurately reconcile controlled medications, related to, the counting and record keeping of	08/25/2013			

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	<p>counting and record keeping of the controlled medications for 1 of 3 Units. (Shepherd's Unit)</p> <p>Findings include:</p> <p>During observation on the Shepherd's Unit on 7/25/13 at 3:10 p.m., RN #1 and LPN#1 counted controlled medications at shift change. Off-going LPN#1 was reconciling medications with the controlled drug book with incoming RN#1. RN #1 looked at Medication Administration Cards and stated the residents' first name and stated how many pills were left on the Medication Card and LPN #1 indicated "yes." There was no indication of what the medication or dosage was being counted. For one drug, Xanax 0.5 mg, the sign off sheet indicated 33, 0.5 mg tablets were delivered on 6/23/13 and there was only room to document 25 doses. Interview with RN#1 at the time indicated the resident received half doses at times. There was documentation of the controlled drug administration on the back of the document sheet that was just written in on the blank paper. Interview with RN#1 indicated the pharmacy had not sent an extra sheet to document controlled medication for a resident who had more pills than the sheet</p>		<p>the controlled medications. I. Specific Corrective Action: The correct numbers of sheets were obtained so all doses could be counted. The controlled medications on Shepherd's Unit were recounted following the correct procedure. II. Identification and correction of others: All units will follow the same policy and procedure for accurately reconciling controlled medications. III. Systemic Changes: A new policy was created to address accurately reconciling controlled medications. All nurses will attend an in-service to review the facility policy and procedure regarding the counting and record keeping of controlled medications prior to August 25, 2013. [Attachments: Narcotic Shift to Shift Count Policy & InserviceNursesPOC8.2013] IV. Monitoring: The DON, ADON and/or designee will witness one random reconciliation daily (Monday through Friday) for one month, then weekly for three months, then monthly for three months. Verification will be designated by signing the count sheet. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance.</p>		

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	<p>could document. She further indicated the former DoN (Director of Nursing) got confused when he looked at the sheets (pain documentation) and he wanted staff to document on the back of the narcotic sheets. When asked if she could ask for more sheets she indicated yes.</p> <p>During an interview on 7/26/13 at 10:30 A.M. the DoN indicated, "My expectation is one nurse is standing at the cart with the sheet with the book they sign off on, while the other nurse is standing at the cart. They should name the resident, the medication, and the count of the medication being counted and verify it is correct."</p> <p>On 7/26/13 at 10:45 A.M., the DoN. provided a copy of the Controlled Medication Storage Policy effective January 2007. It indicated, "A controlled medication accountability record is prepared by the facility for all Schedule II, III, IV, and V medications including those in the emergency supply. The following information is completed: 1). Name of resident, if applicable. 2) Prescription number, if applicable. 3) Name, strength, and dosage form of medication. 4) Date received. 5) Quantity received 6) Name of person</p>				

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	receiving medication supply." 3.1-25(e)(2)				

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F000503 SS=D	<p>483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT</p> <p>If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.</p> <p>If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.</p> <p>If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.</p> <p>If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.</p> <p>Based on record review and interview, the facility failed to ensure clinical laboratory services were arranged and provided for 1 of 1 resident's reviewed for monthly blood/lab draws. (Resident #10)</p> <p>Findings include:</p> <p>Resident #10's clinical record was reviewed on 7/24/13 at 8:50 a.m. Resident #10's diagnoses included, but were not limited to, CVA (Stroke), spinal stimulation, osteoarthritis,</p>	F000503	F503 It is the policy of this facility to have an agreement to obtain necessary laboratory services from a laboratory that meets the applicable requirements of part 493 of this chapter. I. Specific Corrective Action: The physician was immediately contacted regarding the missed lab on Resident #10 and an order obtained to immediately draw the lab. II. Identification and correction of others: All residents have the potential to be affected by missed lab draws. All charts were reviewed to ensure all physician orders for routine	08/25/2013			

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	<p>non-insulin dependent diabetes, insomnia and anemia.</p> <p>Review of the June and July Physician Recapitulation orders, indicated an order dated 5/6/13 for a CMP [sic] w/ diff (should be CBC) and BMP (complete blood count and electrolytes) to be done monthly.</p> <p>Review of the June and July MARs (Medication Administration Record) and TAR (Treatment Administration Record) did not indicate if the labs were completed.</p> <p>Review of the Lab Section of the clinical record, indicated the last CBC and BMP were completed on 5/20/13.</p> <p>An interview with the DoN (Director of Nursing) on 7/24/13 at 12:20 p.m., indicated the labs were not completed. The DoN indicated she had contacted the company who provides lab services and the company indicated they have the labs discontinued.</p> <p>An interview with the DoN on 7/24/13 at 2:00 p.m., indicated she was not able to locate the original written physicians order for the lab in the resident's clinical record.</p>		<p>labs are completed as ordered.</p> <p>III. Systemic Changes: All nurses will attend an in-service to review the facility procedure to be followed regarding laboratory draws prior to August 25, 2013. [Attachment: InserviceNursesPOC8.2013]</p> <p>IV. Monitoring: The DON, ADON and/or designee will review all scheduled routine lab orders to ensure they are drawn as ordered. The audit will occur weekly for four months, then monthly for three months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Laboratory Review]</p>		

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	3.1-49(b)				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify and implement a plan of action to correct a quality deficiency related to laboratory tests and monitoring the effectiveness of pain medications for 2 of 10 residents reviewed for unnecessary medications in a total sample of 19, which had the potential to effect 49 of 49 residents who reside in the healthcare facility. (Residents #10</p>	F000520	F520 It is the policy of this facility to maintain a quality assessment and assurance committee consisting of at least the required members. The quality assessment and assurance committee meets at least quarterly and identifies issues; then develops and implements appropriate plans of action to correct identified quality deficiencies. I. Specific Corrective Action: The physician(s) was notified of laboratory testing that did not get	08/25/2013			

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	<p>and #15)</p> <p>Findings include:</p> <p>During an interview on 7/26/13 at 8:28 a.m. with the DoN (Director of Nursing) and Administrator, The DoN indicated the ADoN (Assistant Director of Nursing) audited the laboratory (lab) testing every month and if there were concerns, then the concern would be added to the QAA. The DoN indicated she was unsure why the lab tests for Residents # 10 and #15 were not completed and why the error had not been found.</p> <p>The DoN indicated the Charge Nurses were to monitor for pain, and then report on the 24 hour report form and if a problem was identified, then the concern would be added to QAA. She indicated the facility was not addressing Resident #10's concerns about the pain medication not working.</p> <p>The DoN indicated the system in place was not working.</p> <p>3.1-52(b)(2)</p>		<p>done. The nurses were re-educated regarding monitoring the level of pain and the effectiveness of the pain medication. II. Identification and correction of others: All residents have the potential to be affected by missed lab draws. All charts were reviewed to ensure all physician orders for labs are completed as ordered. All residents have the potential to be affected by pain assessments not completed per policy. All residents on pain medication were reviewed for proper assessment and management of pain. III. Systemic Changes: All nurses will attend an in-service to review the facility procedure regarding laboratory draws and pain management prior to August 25, 2013. [Attachment: InserviceNursesPOC8.2013] IV. Monitoring: The DON, ADON and/or designee will review all scheduled routine lab orders to ensure they are drawn as ordered. The audit will occur weekly for four months, then monthly for three months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: Laboratory Review] The DON, ADON and/or designee will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2013
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			randomly audit six charts per week of residents on pain medication for three months. It will then decrease to every other week for four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: 24 Hour Condition Report] [Attachment: QA Tracking Log]	