

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2014
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00157994.</p> <p>Survey dates: October 7, 8, 9, 10, 14, 15, &amp; 16, 2014</p> <p>Facility number: 000227 Provider number: 155334 AIM number: 100267520</p> <p>Survey team: Beth Walsh, RN-TC (October 7, 8, 9,14,15,16, 2014) Tom Stauss, RN (October 7, 8, 9,14,15,16, 2014) Karina Gates, Generalist (October 7, 8, 9, 10, 2014) Sherry Nagel-Smith, RN</p> <p>Census bed type: SNF/NF: 150 Total: 150</p> <p>Census payor type: Medicare: 26 Medicaid: 98 Other: 26 Total: 150</p>	F000000	<p>Ms. Kim Rhoades Indiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4B Indianapolis, Indiana 46204</p> <p>November 3, 2014</p> <p>RE: Survey Event ID: X5GT11</p> <p>Dear Ms. Rhoades:</p> <p>Attached you will find the completed Plan of Correction and attachments for our Recertification and State Licensure survey and Complaint Survey (IN00157994). We request that our plan of correction, be considered for a paper compliance desk review.</p> <p>Should you have any questions, please feel free to contact me at (317)353-1290 .</p> <p>Sincerely,</p> <p>Linda Vest Executive Director Kindred Transitional Care and Rehabilitation Wildwood Phone (317) 353-1290 Fax (317) 351-2579</p>	
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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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F000250 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview, and record review, the facility failed to ensure an annually required Pre Admission Screening / Resident Review (PASRR) evaluation was completed for 1 of 1 residents reviewed for PASRR. (Resident #186)</p> <p>Findings Include:</p> <p>Resident #186's record was reviewed on 10/14/14 at 9:59 a.m. The resident's diagnoses included, but were not limited to, myopathy, malnutrition, anemia, anxiety, autism, insomnia, MR, severe debility. The resident's medications included, but were not limited to, remeron, folic acid, trazodone, beneprotein, boost.</p> <p>On 10/15/14 at 2:57 p.m., the Social Services Assistant (SSA) indicated Resident #186 did not have an PASRR</p>	F000250	<p>Cell (317) 756-7119</p> <p>1. The required PASRR for resident # 186 was completed on 10/16/14. On this date, BDDS sent facility a "certification " form dated 10/16/2014. Residents care plan was updated to include new interventions on 10/30/2014. It was explained that since resident #186 has no interest in returning to the community and is not involved with OBRA day services, she does not need an Annual Resident Review done. BDDS was unable to provide a date in which IDEC will be out to do the assessment. Facility is unable to contact IDEC, only BDDS is allowed to make contact</p> <p>2. Review was completed of all residents with a diagnosis of MI/MR/DD to determine what other residents required PASSR . There are 9 residents who were identified. Fax was sent to Adult and Child with residents' names that need to be seen.A Level II binder has been put</p>	11/15/2014

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	<p>Level II services comprehensive assessment completed after the expiration of the most recent PASRR assessment, dated 7/26/2013. She indicated she contacted the state agency representative responsible for the PASRR annual assessments. She indicated a former Social Services Director had kept track of when annual PASRR evaluations need to be completed, but since the former SSD is no longer employed at the facility, she indicated some of the PASRR annual evaluations "may have gotten missed." She indicated there may be other residents who need follow up evaluations, which are coordinated by the Social Services Department, which are not up to date with annual evaluations. The SSA also indicated the most recent PASRR did not have a list of recommendations by which the Social Services department would normally update the resident's care plan for Mental Retardation (MR). She indicated she doesn't know why the most recent PASRR did not include a list of recommendations for care needs. The SSA indicated she updated Resident #186's care plan for MR based on her own assessment of the resident.</p> <p>On 10/16/14 at 10:48 a.m., Social Service Consultant indicated the Social Services department should have followed up with</p>		<p>in place with an alphabetical list of all residents with MI or MR/DD.</p> <p>3. The SSD has been in-serviced on the PASRR procedure.</p> <p>4. The list will be checked the beginning of each month and appropriate agency will be contacted as needed. Social Services will assure that recommendations made are followed and care planned. The Social Services Director will be responsible for monitoring this process to assure compliance. Review of the PASSR residents will be reviewed at monthly PI meeting for at least 6 months or until facility has reached 100% compliance as determined by the PI committee</p>	

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	<p>the PASRR evaluation agency "at least weekly for a few weeks" after 8/14/14 to ensure Resident #186 was evaluated to determine the level of care needed for the Resident.</p> <p>A care plan for MR, dated 8/8/13, indicated the following interventions: "...Encourage resident to participate in facility activities..." and "...Encourage family involvement in decisions that might impact the quality of (Resident #186's name) life</p> <p>A "PRE-ADMISSION SCREENING / RESIDENT REVIEW", with a date of certification of 7/26/13 indicated Resident #186 "...Requires resident review in one year..." and "...Requires Specialized Rehabilitation Services for a developmental disability..."</p> <p>A facility policy, dated 4/28/11 and titled "Pre-Admission Screening for Mental Health/Mental Retardation" indicated "...The center (facility) coordinates assessments with the pre-admission screening and patient review program to the maximum extent practicable to avoid duplicate testing and effort..." and "...Encourage resident to be involved in community events that meet her desires..."</p> <p>3.1-34(a)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 interview and record review, the facility failed to develop a nutrition and dehydration care plan for 1 of 18 residents reviewed for care plans.</p> <p>Findings include:</p> <p>The clinical record for Resident #96 was reviewed on 10/9/14 at 2:05 p.m. The diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, end stage renal disease, and gastroparesis.</p>	F000279	<p>1. On 10 /14/2014 resident # 96 had a care plan developed and reviewed by the RD for dehydration and nutrition. Resident #96, the family and the MD were included in the plan of care.2. All other residents with a diagnosis of dehydration have the potential to be affected. All residents needing a care plan for nutrition to be developed have the potential to be affected. An audit of all residents care plans has been completed and any resident needing a care plan for dehydration or nutrition has been</p>	11/15/2014

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F000282 SS=D	<p>A review of the Admission MDS (Minimum Data Set) assessment, dated 4/29/14, indicated a Nutrition and Dehydration Care Plan needed to be developed for Resident #96.</p> <p>Nutrition and Dehydration Care Plans were not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DON), on 10/9/14 at 3:10 p.m., the DON indicated she was unable to locate a Nutrition or Dehydration Care Plan for Resident #96, but she will look into it further.</p> <p>On 10/14/14 at 11:52 a.m., the DON indicated the Registered Dietician just developed a Nutrition Care Plan for Resident #96. The DON also indicated the facility did an audit of the residents to ensure all residents that triggered for a Dehydration Care Plan had one. The DON further indicated Resident #96 now had a Dehydration Care Plan.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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>developed.3. Education and in-servicing has been completed with the RD and MDS nurse on developing care plans.4. The DNS/Designee will audit the care plan for all admissions to ensure they have a nutrition care plan developed. Then the DNS/Designee will review all care plans quarterly, annually and with significant change to validate care plans are developed for nutrition and any resident with a diagnosis of dehydration. This audit will be completed weekly for three months. All findings will be reviewed in monthly PI meeting and the PI committee will determine when 100% compliance has been achieved. The threshold will be met when 100% of the care plans for nutrition and dehydration are developed by the RD/MDS nurse upon admission and with a patient's significant change. The PI committee will determine if any ongoing monitoring is required when less than 100% is achieved.</p>	

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	<p>Based on observation, interview, and record review, the facility failed to follow physician's orders as written regarding eye drop administration for 1 of 32 residents reviewed for following physician orders. (Resident #83)</p> <p>Findings Include:</p> <p>On 10/15/14 at 12:25 p.m., during a medication administration observation, LPN #7 administered eye drops to the left eye of Resident #83. The medication administered was labeled on the eye drop bottle as artificial tears.</p> <p>On 10/15/14 at 12:28 p.m., during an interview, LPN #7 indicated the physician's order for the eye drops (artificial tears) she administered to Resident #83 indicated for the eye drops to only be administered in the resident's right eye. She indicated the resident had earlier complained of watering in the left eye and she was "going to call the Doctor and get the order changed."</p> <p>A physician's order, dated 2/8/14, indicated "...Natural Tears 2-GTTS (drops) TO R(right)-EYE)..."</p> <p>On 10/15/14 at 1:18 p.m., during an interview, the Director of Nursing (DON)</p>	F000282	<p>1.The MD order for resident #83's artificial tears was changed to administer 2 GTTS to both eyes. Resident, family and the pharmacy were notified of the order change and of LPN administering artificial tears to the left eye and not the right on 10/15/2014.</p> <p>2.LPN #7 has completed Performance improvement to include education on medication administration and following MD orders. All residents receiving eye drops have the potential to be affected. All licensed nurses and QMAs have completed a medication administration skills validation including validation of eye drop administration to validate competence in administration with following physician's orders this was completed by the DNS/Designee and completed by november 15, 2014.3. All Licensed Nurses and QMAs have been in-serviced on Medication Administration with emphasis on following physician's orders.4.The DNS/Designee will complete medication administration to include administering eye drops observations three times a week on all shifts for thirty days, then twice weekly for thirty days, then once a week for thirty days and then Quarterly.The threshold for compliance will be 95-100% on all all medication administration observations. All findings will be reviewed with the</p>	11/15/2014			

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F000309 SS=D	<p>indicated nursing staff should only administer medications as ordered by the physician. She indicated administering eye drops to the wrong eye was considered a medication error.</p> <p>A facility policy, dated 5/1/10 and titled "Medication Administration Times" indicated "...Facility should ensure that authorized personnel, as determined by Applicable Law, administer medications according to the times of administration as determined by the facility's pharmacy committee and/or Physician/Prescriber..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to administer insulin close to a resident's meal time as recommended by pharmacy guidelines for 1 of 32 residents reviewed</p>	F000309	<p>Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 95- 100% compliance is achieved or if continued monitoring or re-education of the licensed nurse is required. All findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 95-100% compliance is achieved.</p> <p>1. The physician for resident # 127 was notified of resident #127 receiving Novolog 4 Units SQ at 11:30am on 10/15/2014 and eating lunch at 1:15PM. Resident, family and pharmacy were notified. 2. LPN #7 has</p>	11/15/2014	

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	<p>for quality of care. (Resident # 127)</p> <p>Findings include:</p> <p>On 10/15/14 at 12:41 p.m., during an interview, LPN #7 indicated she administered 4 units of Novolog insulin to Resident #127 "around 11:30" a.m. She indicated Resident #127 had not received or eaten her lunch meal as of the time of the interview.</p> <p>On 10/15/14 at 1:12 p.m., Resident #127 was observed eating lunch in her room.</p> <p>A physician's order, dated 8/15/14, indicated for Resident #127 to receive "...NOVALOG (sic)..." sliding scale insulin coverage three times daily with meals depending on the resident's blood sugar level. The medication administration record for 10/15/14 indicated Resident #127 received 4 units of Novolog insulin for a blood sugar reading of 226.</p> <p>On 10/15/14 at 1:16 p.m., during an interview, the Director of Nursing (DON) indicated Novolog insulin should be given no more than "20 minutes or so before meals". The DON indicated the facility would consider it a medication error if a nurse gave Novolog more than</p>		<p>completed Performance improvement to include education on medication administration and following MD orders to include education on insulin. All residents receiving insulin have the potential to be affected. All licensed nurses have completed a medication administration skill validation on administering insulin to include following the physician's order and administration in regards to meal times. The DNS/Designee completed an audit of all residents with insulin orders to validate administration with meal times and following physician's orders. 3. All Licensed Nurses have been educated on medication administration, following MD orders and education on insulin administration.4. The DNS/Designee will complete medication administration observations of insulin three times a week on all shifts for thirty days, then twice weekly for thirty days, then once a week for thirty days and then Quarterly.The threshold for compliance will be 100% on all all medication administration observations of insulin administration. All findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 100% compliance is achieved or if continued monitoring or re-education of the licensed nurse is required. All</p>	

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F000323 SS=D	<p>an hour before the resident was to eat.</p> <p>A facility pharmacy policy, dated 2012 and titled "INJECTABLE INSULIN CHECKLIST" indicated for staff to "...start meal within 5-10 minutes..." after a Novolog injection. The policy identified Novolog as a "Rapid Acting" insulin with an onset of the medication from 15 to 30 minutes after its administration.</p> <p>A facility policy, dated 5/1/10 and titled "Medication Administration Times" indicated "...Facility should ensure that authorized personnel, as determined by Applicable Law, administer medications according to the times of administration as determined by the facility's pharmacy committee and/or Physician/Prescriber..."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked while unattended by a licensed nurse. This was</p>	F000323	<p>findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 100% compliance is achieved or if further monitoring or education will be required.</p> <p>1.No residents were harmed. The medication cart on Cambridge unit was locked by the unit manager on 10/7/2014. 2.Performance improvement</p>	11/15/2014			

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	<p>for 1 of 1 medication carts reviewed during a random observation.</p> <p>Findings Include:</p> <p>On 10/7/14 at 12:38 p.m., during an observation, a medication cart was observed to be unlocked. No nursing staff were in the area. The cart was located near the nurses station on the Cambridge unit. The medication cart contained medications for Resident #'s 7, 33, 82, 90, 99, and 184. Some of the medications included, but were not limited to, venlafaxine, dilantin, levetiracetam, carbidopa/levodopa, diltiazem, and amitryptiline. The top right drawer of medication cart had unopened insulin needles in small plastic packages.</p> <p>On 10/7/14 at 1:03 p.m., during an interview, the Director of Nursing (DON) indicated all med carts should remain locked at all times when not attended by a licensed nurse due to the potential for resident harm.</p> <p>A facility policy, dated 1/1/13 and titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" indicated "...Facility should ensure that resident medication and biological storage areas are locked..."</p>		<p>was completed with the Licensed Nurse that left the medication cart unlocked. An audit was completed immediately of all medication carts to validate they were locked if unattended.</p> <p>3.All Licensed nurses have been educated on Accidents and Supervision and Storage and expiration of medications, biologicals and needles.</p> <p>4.The DNS/Designee are completing safety rounds twice daily for 30 days, then once daily for thirty days, then three times a week for 30 days. All findings will be reviewed in the monthly safety and PI meeting. The threshold for compliance will be 100% on all safety rounds weekly. The PI committee will determine when 100% compliance has been achieved and if less than 100% compliance the PI committee will determine if ongoing monitoring will be required.</p>				

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F000329 SS=D	<p>3.1-19(c) 3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to utilize non-pharmacological interventions prior to administration of psychoactive medication, monitor behaviors associated with psychoactive medication use and determine effectiveness of psychoactive</p>	F000329	1.Resident # 255 has non-medicinal approaches included in her plan of care and a Behavior Monitoring sheet with identified approaches included placed with the MAR for documentation and monitoring. Resident # 20 has a Behavior Sheet for monitoring and	11/15/2014

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	<p>medication use for 2 of 5 residents reviewed for unnecessary drugs (Resident #20 &amp; #255)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #255 was reviewed on 10/14/14 at 10:05 a.m. The diagnoses for Resident #255 included, but were not limited to, diabetes mellitus, sacral decubitus ulcer, discoid lupus, emphysematous gastritis and history of diabetic ketoacidoses.</p> <p>A review of the MAR (Medication Administration Record) indicated Resident #255 received PRN (as needed) clonazepam 1 milligram for anxiety on 10/5/14 and 10/9/14.</p> <p>Non-medicinal approaches prior to the administration of the PRN clonazepam were not located in the clinical record.</p> <p>During an interview with LPN #5, on 10/14/14 at 11:59 a.m., she indicated she only attempted non-medicinal approaches prior to the administration of PRN anti-anxiety medication on occasion. LPN #5 indicated if she would do a non-medicinal approach prior to the administration of an anti-anxiety medication, she would document the approach/es on the back of the MAR.</p>		<p>documentation of non-medicinal approaches for insomnia. The MD for Resident #20 discontinued the PRN ambien and increased the trazadone to 100mg po PRN Q hs.</p> <p>2.All residents receiving psychotropic medications have the potential to be affected. An audit of all residents receiving psychotropic medications has been completed to validate Behavior Monitoring Sheets include non-medicinal approaches and are in place with the MAR. An audit of the MDS for all residents receiving a psychotropic medication has been completed and any MDS needing correction will have a corrected MDS submitted. An audit of SS documentation for validation of documentation to address all residents receiving a psychotropic medication has been completed.</p> <p>3.Education has been provided on Psychotropic Medications, documentation of non-medicinal approaches utilized prior to administration of psychotropic PRN medications and the effectiveness after administering psychotropic PRN medications with all licensed nurses and the SSD/SSA.</p> <p>4.The DNS/Designee will audit weekly for 30 days, any resident with an order for a PRN or new psychotropic medication to validate the diagnosis, care plan with non-medicinal interventions, the Behavior Monitoring Sheet, the SS progress note and the MAR have documentation completed. Then twice a month for 30 days, then</p>		

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	<p>On 10/14/14 at 12:10 p.m., the Director of Nursing (DON) indicated non-medicinal approaches should be tried prior to the administration of PRN anti-anxiety medication and the approaches should be documented on the behavior sheets with the MAR. The DON also indicated she did not see any non-medicinal approaches prior to the administration of the PRN clonazepam listed above.</p> <p>At 12:16 p.m., on 10/14/14, the Social Services Assistant indicated non-medicinal approaches should be attempted prior to the administration of anti-anxiety medication and the approaches should be documented on the behavior sheets with the MAR. The SSA further indicated she has not gotten around to putting a behavior sheet with the MAR for Resident #255 and she was not aware that Resident #255 had received PRN anti-anxiety medication.</p> <p>A policy titled, Psychoactive Drug Use, dated 8/31/12, was received from the DON on 10/14/14 at 1:32 p.m. The policy indicated, "...10. Attempt alternative methods to psychoactive drug use and document effectiveness..."</p> <p>2. Review of Resident #20's clinical</p>		<p>monthly as an ongoing practice of this facility. The DNS/Designee will report all findings to the PI committee monthly and the PI committee will determine when 100% compliance is achieved.</p>				

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	<p>record 10/14/2014 at 11:13 a.m. indicated resident had diagnoses of, but not limited to, chronic obstructive pulmonary disease, depression, mood disorder, neuropathy, angina, dementia without behaviors and insomnia.</p> <p>Physician monthly orders for August and September 2014 indicated resident received, but not limited to, Citalopram (Celexa) 20 milligrams (mg) tab, give one tab orally (PO) daily (QD) at 8:00 a.m., Olanzapine ODT (Zyprexa) 5 mg tab, give one tab PO or sublingual QD at 8:00 p.m., Ambien (Zolpidem) 5 mg tab, give one tab PO QD at bedtime (HS) as needed (PRN) for insomnia and Trazadone 25 mg tab, give one tab PO QD at HS for insomnia. Notation on orders indicated to use Trazadone first for insomnia.</p> <p>Medication Administration Record (MAR) August 13 through August 29, 2014 indicated resident received Ambien and Trazadone thirteen (13) of the seventeen (17) days at the same time at 8:00 p.m. Reason medications were given each day was documented as "insomnia." Response to medications was documented as "effective" at 10:00 p.m. each day.</p> <p>Controlled Substance Record indicated</p>						

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	<p>resident received Zolpidem September 1 through September 4, September 8, 10 and 19, 2014. Neither MAR for September 2014, nor nursing progress notes indicated reason medication was given or effectiveness of the medication .</p> <p>In interview 10/15/2014 at 2:00 p.m., LPN #6 indicated date and time PRN medications were to be charted on the MAR in addition to the reason given and response to medication.</p> <p>In interview 10/16/2014 at 11:12 a.m., DON indicated PRN medications were to be charted on MAR along with the reason given and response to medications. DON indicated other approaches should be attempted and charted prior to giving the PRN medication.</p> <p>On 10/14/2014 at 1:32 p.m. DON presented the Psychoactive Drug Use policy. Policy indicated "attempt alternative methods to psychoactive drug use and document effectiveness."</p> <p>During interview 10/16/2014 2:30 p.m. DON indicated that resident should have had Behavior Monitoring Sheets for August and September 2014 that addressed interventions for resident's insomnia, but was not able to find the sheets. October Behavior Monitoring</p>						

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	<p>Flowsheet provided by Social Service Assistant 10/16/2014 at 1:59 p.m. indicated interventions of providing quiet dimly lit room for sleep and adjust temperature for comfort PRN, none of which were documented prior to administration of the PRN Zolpidem or Trazadone.</p> <p>Resident care plans initiated 7/22/2014 identified problems of hypnotic medication use and potential for sleep problem related to diagnosis of insomnia. Goals included resident will be free of signs / symptoms of sleep deprivation and will report obtaining sufficient sleep for daily functioning. Interventions were to administer medications as ordered, see medication record; Monitor for effectiveness and side effects; observe resident to investigate and identify potential sources of sleep disturbances; provide quiet, dimly lit room for sleep and adjust room temperature for comfort PRN; observe for and changes/worsened mood, document and notify physician, nurse and/or social service.</p> <p>Pharmacy Review dated 8/21/14 indicated pharmacist recommendations to reevaluate the appropriateness of Zyprexa and the continued use of combination of Trazadone and Zolpidem. Nurse Practitioner declined recommendation.</p>			

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	<p>Note dated 7/23/2014 was addressed to DON with recommendations to provide detailed documentation of, but not limited to, specific diagnosis/indication requiring treatment and risk verses benefit evaluation; symptom, criteria/target behaviors; ongoing monitoring of specific target behaviors; and efficacy of individualized, non-pharmacological approaches.</p> <p>Social Service Progress notes dated 9/12/2014 did not address resident's use of PRN hypnotic for insomnia. Notes indicated resident feels tired and depressed 2-6 days a week. During interview 10/16/2014 at 1:59 p.m., Social Service Assistant indicated she usually addressed psychoactive med use in her progress notes, but may have missed one.</p> <p>Psychologist progress note 7/15/2014 suggested that employing supportive manner in interacting with resident would be helpful and 9/17/2014 note indicated resident was appreciative of opportunities for social interaction.</p> <p>Quarterly Minimum Data Set (MDS) assessment with target date 9/8/2014 indicated resident received no hypnotic medication though records indicated resident received hypnotic four times during the assessment reference period.</p>			

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F000332 SS=D	<p>When informed of coding error 10/15/2014 11:01:20 AM, DON indicated she was aware of problem.</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% was maintained during medication pass observations. The actual rate of medication errors for the facility was 6.667% This affected 1 of 11 residents observed and reviewed for medication pass. (Resident #167)</p> <p>Findings include:</p> <p>On 10/14/14 at 9:43 a.m., during an observation of a medication administration, LPN #9 administered Humalog insulin to Resident #167. The resident was lying in her room in her bedroom during the time of the insulin administration and no breakfast items were observed in the resident's room at the time.</p>	F000332	<p>1.The physician, resident # 167 and family were notified of medications administered late and missed metformin on 10/14/2014 during am med pass. The metformin was filled from the pharmacy and at the facility on 10/14/2014. Resident #167 was not harmed.</p> <p>2.All other residents receiving medications have the potential to be affected. LPN #9 has completed performance improvement to include medication administration observation skills validation. An audit of medications to MAR has been completed to validate all medications are available for administration.</p> <p>3.All licensed nurses have completed education on medication administration and medication availability and ordering.</p> <p>4.The DNS/Designee will complete medication</p>	11/15/2014

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	<p>On 10/14/14 at 9:45 a.m., during an interview, LPN #9 indicated Resident #167 ate breakfast "earlier" on 10/14/14. She indicated not knowing an exact time when the resident ate breakfast on 10/14/14.</p> <p>On 10/14/14 at 9:47 a.m., during an observation of an oral medication administration, LPN #9 administered scheduled medications to Resident #167. The medications included lisinopril and folic acid.</p> <p>On 10/14/14 at 9:48 a.m., during an interview, LPN #9 indicated she was unable to give Resident #167 her metformin, scheduled for 9:00 a.m. on 10/14/14, due to the medication supply having run out. She indicated she would look elsewhere in the facility or obtain a refill for the resident's metformin from the facility pharmacy.</p> <p>On 10/14/14 at 10:07 a.m., during an interview, the Director of Nursing (DON) indicated Metformin should be given as ordered for the medication to be effective. She indicated all residents' medications should be administered as ordered by the physician.</p> <p>On 10/14/14 at 10:31 a.m., during an</p>		<p>administration observations three times a week on all shifts for thirty days, then twice weekly for thirty days, then once a week for thirty days and then Quarterly. The threshold for compliance will be 95-100% on all all medication administration observations. All findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 95- 100% compliance is achieved or if continued monitoring or re-education of the licensed nurse is required.</p>	

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	<p>interview, the DON indicated Resident #167's folic acid, lisinopril, and humalog insulin were administered late by LPN #9. She indicated those administrations were considered medication errors according to facility policy. She indicated the Physician was notified of the medication errors and a "variance sheet" will be completed for the medication errors according to facility policy.</p> <p>On 10/16/14 at 1:09 p.m., the DON indicated Resident #167 did not receive a dose of metformin scheduled for 10/14/14 at 9:00 a.m. She indicated the resident received her scheduled 5:00 p.m. dose of metformin the same day. She indicated the resident's physician was notified of the medication omission.</p> <p>A medication administration record for October of 2014 indicated for Resident #167 to receive lisinopril, folic acid, A facility policy, dated 2012 and titled "INJECTABLE INSULIN CHECKLIST" indicated Humalog insulin "...can be given within 15 minutes before or immediately after a meal..."</p> <p>A facility policy, dated 5/1/10 and titled "Medication Administration Times" indicated "...Facility should ensure that authorized personnel, as determined by Applicable Law, administer medications</p>			

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F000333 SS=D	<p>according to the times of administration as determined by the facility's pharmacy committee and/or Physician/Prescriber..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error of an excessive dose of insulin for 1 of 5 residents reviewed for unnecessary medication. (Resident #255)</p> <p>Findings include:</p> <p>The clinical record for Resident #255 was reviewed on 10/14/14 at 10:05 a.m. The diagnoses for Resident #255 included, but were not limited to, diabetes mellitus, sacral decubitus ulcer, discoid lupus, emphysematous gastritis and history of diabetic ketoacidoses.</p> <p>A review of a Physician's Order, dated 10/7/14, indicated blood sugar (blood</p>	F000333	<p>1. Resident #255 HS blood sugar noted to be 460, per orders resident was to receive 10 units of insulin. Resident was administered 100 units of insulin. MD/NP notified, resident assessed, new orders obtained and initiated. D10 IVF started per orders. Accu- checks monitored per orders. MD, DNS, ED, Resident notified. Additional orders carried out. Resident #255 had no harm.</p> <p>2. All other residents receiving insulin assigned to the licensed nurse completing the insulin error had accu -checks obtained to validate WNL. The licensed nurse was removed from the schedule until she completed performance improvement to include skills validation on insulin administration. Upon returning to work the licensed nurse received</p>	11/15/2014

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	<p>glucose) checks should be completed every 4 hours and the sliding scale of insulin below should be administered according to the blood glucose result: 150-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units.</p> <p>The October MAR (Medication Administration Record) for Resident #255 indicated a blood glucose result of 564 around 4 p.m. The MAR indicated 100 units were given at this time. There was a circle drawn around the 100 units. The MAR also indicated Resident #255 had a blood glucose result of 400 around 8 p.m. There was documentation of the number 100 with a line marked through it and the word "error" written in the column for amount of insulin administered for the blood glucose result of 400. The back of the MAR had the following documentation, "...10-7 [10/7/14] 1700 [5 p.m.] 100 units written in error actually gave 12 units...10/7 [10/7/14] 2100 [9 p.m.] 100 units circled in error actually given [sic] 100 u [units]. Error reported to NP [Nurse Practitioner]."</p> <p>A Progress Note, dated 10/7/14 at 10:33 p.m., indicated, "...At 2000 [8:00 p.m.]</p>		<p>additional orientation. The LPN will have any insulin that is due to be administered verified by a second nurse prior to administration for the next 30 days; after this 30 day period she will be re-evaluated as to if she may administer insulin independently with periodic checking for nurse administration.</p> <p>3.All Licensed nurses have completed education on insulin administration.</p> <p>4.The DNS/Designee will complete medication administration observations of insulin three times a week on all shifts for thirty days, then twice weekly for thirty days, then once a week for thirty days and then Quarterly.The threshold for compliance will be 95-100% on all medication administration observations. All findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 95- 100% compliance is achieved or if continued monitoring or re-education of the licensed nurse is required. All findings will be reviewed with the Licensed Nurse and in monthly PI meeting and the PI meeting will determine when 95- 100% compliance is achieved</p>	

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	<p>BS [blood sugar/glucose] was checked again. BS was again check [sic] per MAR order and was still high. Writer called NP to notify of continuing high sugar. In error writer mistakenly gave 100units [sic] of insulin. When night shift nurse arrived and report was given of resident's BS and of the error the writer made. Night shift nurse and writer quickly checked BS and assessed resident. Night shift nurse and writer began interventions. NP called back and was notified of error, NP gave orders."</p> <p>A Physician's Order, dated 10/7/14 at 10:30 p.m., indicated to give D10 (concentrated sugar solution) via IV (intravenous) at 50 ml (milliliters) an hour for 5 hours for "prevention." The order also indicated to start 15 minute blood glucose checks for 2 hours.</p> <p>A Physician's Order, dated 10/8/14 at 12:00 a.m., indicated to give glucagon (medication to raise blood glucose levels) 1 mg (milligram) intramuscularly for blood glucose result of 53 (low blood glucose result).</p> <p>A Physician's Order, dated 10/8/14 at 2:00 a.m. indicated to give glucagon 1 mg intramuscularly for blood glucose result of 66 (low blood glucose result).</p>				

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	<p>During an interview with the Director of Nursing (DON), on 10/14/14 at 2:50 p.m., the DON indicated LPN#12 told the DON she mistakenly gave the 100 units of insulin to Resident #255 because she (LPN #12) was overwhelmed. The DON further indicated the insulin error was caught during shift report/change when LPN#12 told LPN#13 Resident #255's blood glucose results and the amount of insulin given for the blood glucose results. The DON also indicated LPN#13 verified 100 units of insulin were administered by holding up an insulin syringe to LPN#12, indicating the entire syringe would be filled if LPN#12 gave 100 units to Resident #255. The DON indicated LPN#12 indicated she filled the whole syringe with insulin when she administered it to Resident #255.</p> <p>A policy titled, Medication Management, dated 8/31/14, was received from the DON on 10/9/14 at 9:45 a.m. The policy indicated, "...<b>Medication Error</b> The observed preparation or administration of drugs or biologicals that is not in accordance with: Physician's Orders....<b>Significant Medication Error</b> A medication error causing the resident discomfort or jeopardizing his/her health and safety...."</p> <p>At 1:50 p.m., on 10/16/14, the DON</p>						

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F000441 SS=F	<p>indicated the administration of 100 units of insulin to Resident #255 was considered a significant medication error.</p> <p>3.1-48(c)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact</p>			

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	<p>for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record, the facility failed to ensure an infection control/Contact Isolation/Precautions policy followed the Centers for Disease Control (CDC) guidelines regarding Clostridium difficile (C.diff) isolation precautions. The facility also failed to ensure staff followed contact isolation precautions, when entering resident's rooms that had the diagnosis of C. diff. This had the potential to affect 150 residents that resided in the facility. (Resident #255 &amp; #266)</p> <p>Findings include:</p> <p>1. During a random observation on 10/7/14 at 1:57 p.m., a sign indicating to see the nurse prior to entrance was noted on Resident #255's door.</p> <p>During an interview with LPN #11, on 10/7/14 at 2:00 p.m., LPN #11 indicated Resident #255 had the diagnosis of C. diff. and was in contact isolation.</p> <p>During a random observation, on 10/8/14</p>	F000441	<p>1.The Nursing Center Division Senior Vice President of Clinical Operations and the Clinical Program Director are reviewing the PRO 68014 Transmission Based Precautions and PRO 68024 Clostridium Deficile with the CDC guidelines. Resident # 255 discharged to the hospital on 10/31/2014 and resident #266 discharged home.</p> <p>2.No other residents in the facility acquired a nosocomial infection.</p> <p>3.All staff have been educated and in-serviced on Transmission Based Precautions with emphasis on donning and gowning with contact precautions.</p> <p>4.The DNS/Designee will complete infection control rounds twice daily for 30 days, then once daily for 30 days, then weekly for 30 days. The threshold for compliance will be 95-100% on all infection control rounds completed. All findings will be reported to the PI committee and Infection Preventionist monthly in the PI meeting. The PI committee will determine when 95- 100% compliance is achieved if further monitoring is required for infection control work practices.</p>	11/15/2014

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	<p>at 1:34 p.m., a visitor was observed stopping at the entrance of Resident #255's room, pointing to the sign noted above, looking back at the Nurse's station, and entering the room. The visitor was observed standing next to Resident #255's bed with his pant legs touching the bed. There were 4 staff members at the the Nurse's station next to Resident #255's room, including LPN #11. The visitor left Resident #255's room at 1:38 p.m. The visitor did not don gloves or a gown prior to entrance to the room or while in Resident #255's room. The same visitor returned to Resident #255's room with a case of soda, at 1:41 p.m., and the visitor did not don gloves or a gown prior to entrance to Resident's room. There were still 4 staff members at the Nurse's station.</p> <p>At 2:15 p.m., on 10/8/14, the DON indicated staff were to instruct visitors of residents in contact isolation on how to don a gown and gloves prior to entrance to the Resident' #255s room.</p> <p>On 10/8/14 at 3:48 p.m., LPN #1 was observed in Resident #255's room without a gown and gloves on touching Resident #255's bed while she passed Resident #255 a cup.</p> <p>During a random observation, on 10/9/14</p>						

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	<p>at 9:45 a.m., CNA #2 was observed walking into Resident #255's room without donning gloves or a gown. CNA #2 was observed passing Resident #255's bed and touching a chair in Resident #255's room.</p> <p>On 10/9/14 at 9:50 a.m., the DON indicated an inservice was provided to the facility staff the previous night regarding contact precautions and CNA #2 should've followed CDC guidelines and don a gown and gloves prior to entrance to Resident #255's room.</p> <p>2. During a random observation, on 10/15/14 at 3:47 p.m., LPN #10 entered Resident #266's room to administer medication to Resident #266. LPN #10 was observed giving the medication to the resident and then LPN #10 held up a cup with a straw in it for the resident to drink from. LPN #10 did not don gloves or gown prior to entrance to Resident #266 's room or at any time during their encounter with the resident.</p> <p>During an interview with LPN #10, on 10/15/14 at 3:48 p.m., LPN #10 indicated Resident #266 was in isolation and on "contact precautions " for C. diff.</p> <p>A document, no title or date, provided by the Infection Control Nurse, on 10/15/14</p>			

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	<p>at 2:30 p.m., indicated Resident #255 and Resident #266 were admitted to the facility with the diagnosis of C. diff.</p> <p>3. A policy titled, Managing Patients with Clostridium difficile infection, dated 8/31/14, was received from the Director of Nursing (DON) on 10/7/14 at 2:52 p.m. The policy indicated, "...The ability of these organisms to produce spores explain how C. difficile, a fastidiously anaerobic organism [organism that can grow without oxygen and have complex nutritional requirements] in its vegetative state, can be acquired from the environment....10...b. Contact Precautions and any facility-specific measures should be initiated as directed by the facility protocol.</p> <p>During an interview with the Director of Nursing (DON), on 10/8/14 at 12:12 p.m., the DON indicated the facility follows their policy.</p> <p>Another policy titled, Transmission-Based Precautions, dated 8/31/13, was received from the DON, on 10/8/14 at 2:15 p.m. The policy indicated, "<b>Contact Precautions</b>...4. Gloves a. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed</p>			

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	<p>rails)....5. Gowns a. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. b. Don gloves if exposure is anticipated...."</p> <p>"How can Clostridium difficile Infection Be Prevented in Hospitals and Other Healthcare Settings," (last updated 3/6/12) was retrieved on 10/8/14 at 8:57 p.m., from the Centers of Disease Control (CDC) website. The guidance indicated to, "...Use gloves when entering patient's rooms and during patient care....use gowns when entering patient's rooms and during care...."</p> <p>On 10/8/14, at 3:48 p.m., the DON indicated the facility should follow Centers for Disease Control (CDC) guidelines.</p> <p>The DON indicated, on 10/9/14 at 9:50 a.m. the facility's corporate office was made aware the facility's policy does not follow the CDC guidelines, after the DON reviewed the CDC guidelines.</p> <p>At 11:00 a.m., on 10/14/14, the Infection Control Nurse indicated the facility's corporate office knows the above policies do not follow CDC guidelines.</p>						

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	<p>A document, no title and dated 10/14/14, was received from the DON on 10/14/14 at 3:15 p.m. The document indicated, "...I am [name of RN], Clinical Program Developer and I manage the policies and procedures for the Nursing Center Division. I will be review [sic] and revising with the Senior Vice President of Clinical of Operations the PRO 68014 Transmission Based Precautions [policy listed above] to include the enteric precaution procedures of PRO 68024 Clostridium Deficile [sic]-Associated Diarrhea is also addressed...."</p> <p>3.1-18(b)(2) 3.1-18(a)</p>			