

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00125277, Complaint IN00125615, Complaint IN00127672, and Complaint IN00128175.</p> <p>Complaint IN00125277 - Unsubstantiated due to lack of evidence. Complaint IN00125615 - Unsubstantiated due to lack of evidence. Complaint IN00127672 - Substantiated. Federal and State deficiencies related to the allegations are cited at F282 and F514. Complaint IN00128175 - Substantiated. Federal and State deficiencies related to the allegations are cited at F155, F157, F203, F205, F282, F309 and F514.</p> <p>Survey dates: May 28, 29, 30, 31, June 3, 4 and 5, 2013</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Survey Team: Gloria J. Reisert MSW, TC Debra Peyton RN</p>	F000000	Attached you will find the completed Plan of Correction and attachments for the recertification and state licensure and complaint survey dated June 05, 2013. We respectfully request that our plan of correction, be considered for a paper compliance desk review.	

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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	<p>Gwen Pumphrey RN</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 13 Medicaid: 77 Other: 10 Total: 100</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/13/13 by Suzanne Williams, RN</p>			

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on record review and interviews, the facility failed to incorporate the resident/responsible party's choice regarding Advanced Directives of "Do Not Resuscitate", no tube feedings or artificial life support as stated in the Living Will into care and treatment. This deficient practice affected 1 of 3 residents reviewed for Advanced Directives. (Resident #B)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident was admitted to the facility from the hospital on 3/7/13</p>	F000155	<p>I. Resident B is no longer a resident of the facility.</p> <p>II. All residents with advanced directives have potential to be affected. A 100% chart audit was completed on all residents in the facility to ensure advanced directives have been executed and documentation has been reviewed.</p> <p>III. The SDC or designee will in-service the admissions coordinator, social services director, and licensed nurses on the residents' right to establish advanced directives upon admission.</p>	07/05/2013	

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	<p>and had diagnoses which included, but were not limited to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p> <p>Review of the Nursing notes dated 3/16/13 indicated the resident began experiencing seizure-like symptoms and paramedics were notified in order to transfer the resident to the hospital. The hospital emergency room note indicated that because of the resident's continuous seizures, the resident's airway needed to be protected and the resident was subsequently intubated.</p> <p>During an interview with the resident's responsible party on 6/3/13 at 3:18 p.m., she indicated she had brought in a copy of the resident's Living Will and had given it to the Admissions Coordinator when she signed some of the Admit paperwork on 3/13/13 - 6 days after the resident was admitted. She indicated she had made the Admissions Coordinator aware the resident's Living Will indicated the resident was to have no life support and was to be a DNR.</p> <p>During the interview with the responsible party, she also indicated</p>		<p>IV. The Director of Nursing or designee will audit admissions 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days to validate advanced directives have been addressed and resident's choice documented. Audit results will be reviewed in monthly PI meeting until 100% compliance as determined by PI committee has been achieved.</p> <p>V. Date of Completion July 5, 2013.</p>		

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	<p>that upon arriving at the hospital on 3/16/13, she had observed that the hospital staff had intubated the resident. She indicated that when she asked the staff why since the resident had a Living Will which stated no life support and DNR, the hospital staff had told her it was because no paperwork regarding her wishes towards Advanced Directives had accompanied the resident to the emergency room for them to go by.</p> <p>Review of the 3/7/13 Admitting orders written by the facility failed to address the resident's code status.</p> <p>Documentation was also lacking of the Admissions Coordinator having given the responsible party information on and discussed Advanced Directives with them at time of admission on 3/7/13.</p> <p>Review of the cover page of the resident's clinical record indicated that she was to be a "FULL CODE-RESUSCITATE".</p> <p>Review of the Hospital Patient transfer Form dated 3/7/13 indicated the resident was to be a "DNR" [Do Not Resuscitate]. The admitting nursing assessment dated 2/23/13 also indicated the resident had an</p>			

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	<p>Advance Directive as indicated in her Living Will and was a DNR.</p> <p>Review of the Admission File on 6/4/13 at 8:30 a.m. as well as during the clinical record review, failed to locate a copy of the Living Will. The Admission File did contain a form dated 3/13/13 and titled "Advance Directives" which had 2 sections. One section indicated the Center Representative was told an Advanced Directive exists but copies were not produced. The Living Will line was initialed by the Admissions Coordinator. The other section indicated an Advanced Directive had been received and placed in the resident's clinical record. Do Not Resuscitate/DNR was marked.</p> <p>Documentation was lacking of the Admissions Coordinator having followed through with nursing to obtain a Physician's order for the DNR as well as signing the State DNR form.</p> <p>The Advanced Directives section of the 3/14/13 Initial Psychosocial Profile completed by the Social Worker was observed to have been blank.</p> <p>During an interview with the Social Work Director on 6/3/13 at 2:10 p.m.</p>				

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	<p>she indicated "I can't explain why this form (Advanced Directive) had DNR on it for 3/13/13 but no order was obtained nor the actual DNR form completed also. I just don't know. Usually I also mark what her Advanced Directive wishes were on her Initial Psychosocial Assessment but I see I didn't on hers."</p> <p>During an interview with Administrator #1 on 6/4/13 at 9:00 a.m., she indicated she had called the former Admissions Coordinator who indicated to her that the family was supposed to bring in the resident's Living Will but never did. The Administrator indicated the Admissions Coordinator, Social Worker or Nursing should have followed up with the family on their Advanced Directive wishes and that the Advanced Directives should have designated and signed on the day of admission - 3/7/13, not discussed with the family 6 days later.</p> <p>During an interview with LPN #3 on 6/4/13 at 9:15 a.m., she indicated she had had a conversation with the resident during her 9 days stay in which she discussed the resident's wishes with her and indicated that the resident had told her she didn't care what her family member wanted, she</p>			

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	<p>wanted to be a full code. When queried as to when this conversation took place, LPN #3 was unable to recall and also indicated she did not document the conversation nor let Social Services know.</p> <p>On 6/3/13 at 3:00 p.m., RN #1 presented a copy of the facility's current policy titled "Advance Directives". Review of this policy at this time included, but was not limited to: "rationale: The patient has the right to establish advanced directives as to his/her wishes regarding treatment options and end of life care. Procedure: 1. On admission, furnish the patient information regarding the right to accept or refuse treatment and the right to formulate an advance directive. 2. If an advance directive exists, obtain a copy of Advance Directives from the patient...3. Place a copy of existing advance directives...in the patient's medical record...5. Follow up after admission to assist in completing a health care proxy or to locate existing documents..."</p> <p>This Federal tag is related to Complaint IN00128175.</p> <p>3.1-4(f)(4)(A)(ii) 3.1-4(f)(5)</p>			

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	3.1-4(f)(7) 3.1-4(f)(10)				

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F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide the "General Notice of Medicare Non-Coverage" to 2 of 3 Medicare A residents reviewed upon discharge to home although Medicare benefit days were still available. (Residents #36 and and #119)</p> <p>Findings included:</p> <p>During the review of the liability notices of 3 residents who had been discharged from Medicare in the last 6 months on 5/30/13 at 2:30 p.m., Residents #36 and 119's files were missing the Notice of Medicare Non-Coverage upon discharge from the facility.</p> <p>During an interview with the Business Office manager on 5/30/13 at 3:10 p.m., she indicated "we don't issue letters when residents go home - never have - even if they had days left. (Residents #36 and #119) went home and both had Medicare days left."</p> <p>3.1-4(l)(1)</p>	F000156	<p>I. Resident #36 and #119 have been issued the Notice of Medicare Non-Coverage.</p> <p>II. All discharged residents have potential to be affected. A 100% chart audit was completed on all residents discharged from the facility within the last 30 days to ensure Notice of Medicare Non-Coverage was issued.</p> <p>III. The SDC/ designee will in-service all facility business office employees on the Notice of Medicare Coverage Instructions.</p> <p>IV. The Business Office Manager/ designee will audit discharged records for timely issuance of Notice of Medicare Non-Coverage weekly x 30 days, then monthly x 3 months, then quarterly. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V. Completion date July 5, 2013.</p>	07/05/2013			

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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 interviews, the facility failed to make a referral to the neurologist in a timely manner when the resident began experiencing jerking-like symptoms</p>	F000157	<p>I. Resident B has been discharged.</p> <p>II. All residents have potential to be affected. A chart audit for physician and family/responsible</p>	07/05/2013			

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	<p>and failed to notify the responsible party per request whenever the resident's blood sugar was low. This deficient practice affected 1 of 3 residents reviewed for changes in condition. (Resident #B)</p> <p>Findings included.</p> <p>Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident was admitted to the facility from the hospital on 3/7/13 and had diagnoses which included, but were not limited to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p> <p>A. Review of the admitting physician orders indicated they were signed by the physician on 3/14/13, but the 3/7/13 nursing admit note indicated the orders were verified and confirmed with him on admission.</p> <p>The admitting orders included, but were not limited to: "Hypoglycemic Treatment Order, if applicable: follow center protocol - check blood glucose every 15 minutes, until blood sugar is over 70. - If unable to take po [by mouth], give 1 mg of Glucagon IM [intra- muscular] - max IM/IV dose 1 mg - repeat in 20</p>		<p>representative notification of change in condition for past 30 days was completed.</p> <p>III. SDC/designee will in-service all licensed nurses on timely physician and family/responsible party notification of change of condition by July 5, 2013.</p> <p>IV. Director of Nursing/ designee will audit the 24 hour report for resident change of condition with timely physician and family/responsible party notification of change of condition weekly x4, then bi-weekly x2. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance.</p> <p>V. Completion date: July 5, 2013.</p>				

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	<p>minutes, may utilize medication E-kit supplies, notify physician. - if able to take po, provide oral carbohydrates according to 15/15 rule; repeat in 15 minutes PRN [as needed]. Give additional snack if more than 1 hours to next meal."</p> <p>On 6/3/13 at 9:35 a.m., Administrator #1 presented a copy of the facility's current policy titled "Blood Glucose Monitoring Using a Nova Stat Strip Glucometer." Review of this policy at this time included, but was not limited to:...c. patient unresponsive - give 1 ampule (50 ml) [milliliters] of 50% dextrose IV [Intravenous]. d. check blood glucose every 15 minutes, until blood sugar is over 70 mg/dl. If 15 min [minutes] after treatment shows continued hypoglycemia, treatment should be repeated. e. If blood sugar continues to fall after 15 minutes or continues to be below 70 mg/dl after 30 minutes, call physician. 41. If blood sugar remains less than 70 mg/dl, notify the physician and follow the physician's order as applicable..."</p> <p>Review of the nursing notes between 3/7/13 and 3/16/13 indicated the following notations were made regarding the resident's blood sugars: - "3/13/13 140 am - called to room by roommate stating resident making a</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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	<p>funny noise. Assessed resident. Resident noted to be unresponsive to verbal and painful stimuli, checked BS and was 18...Glucagon injection given, after 5 min BS 26...150 am - rechecked BS 32, resident continued to be non-responsive, called to MD. 2nd Glucagon injection given. After 5 min 2 AM BS 46, resident starting to arouse by arm and leg movement...Recheck BS 210 am - 56, 215 am 63, resident opening eyes and continue to move upper and lower extremities is moaning...Resident given Glugen gel. 225 am BS 75..." Family was notified at 6:40 a.m.</p> <p>- "3/13/13 4 am - went to check on resident, res [resident] cont [continues] to be groggy,opens eyes when spoken to, but mumbles speech, re-checked BS [blood sugar] 42, call to [name of physician], new order to give Dextrose 50 one amp, hold Glipermide [a diabetic medication] today and decrease to 2.5 mg daily." The next documented BS reading was at 6 A.M. - 2 hours after the first reading.</p> <p>- "3/13/13 6 AM - IV access obtained...Dextrose 50 1 amp given IV push, BS at this time 56..." The next documented blood sugar reading</p>			

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	<p>was at 6:30 a.m.</p> <p>- "3/13/13 1630 [4:30 p.m.] - Accucheck 50 - given oj with 2 packs of sugar added and given to resident."</p> <p>- "3/13/13 1730 [5:30 p.m.] - Accucheck 50 - encouraged to drink other half of previous glass of oj." The next documented blood sugar reading was at 9:00 p.m. in which the reading was 64. Juice and nutritional supplement were given, but documentation was lacking of any additional blood sugar readings until 30 minutes later.</p> <p>- "3/13/13 2130 [9:30 p.m.] BS 57 - oj [orange juice] given - no apparent distress noted. No involuntary movements noted. Will continue to observe." The next documented blood sugar reading was at 2 A.M. on 3/14/13.</p> <p>- "3/14/13 2 am - BS 67 continue to offer food and fluids." The next documented blood sugar reading was at 7:00 a.m. No additional blood sugar readings were documented until 3/15/13 at 7:00 a.m..</p> <p>- "3/16/13 0200 [2:00 a.m.] - res BS 68 - OJ given at resident request. At 0230 [2:30 a.m.] BS was up to 99."</p>				

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	<p>Documentation was lacking of the family having been notified of the low blood sugar readings per request.</p> <p>During an interview with the responsible party on 6/3/13 at 3:18 p.m., she indicated she had told nursing that she wanted to be called at anytime of the day if there was a change in the resident's condition, especially her blood sugars. She indicated she did not care if it was in the middle of the night.</p> <p>During an interview with LPN #1 on 5/30/13 at 11:30 p.m., she indicated it was up to the individual nurse as to whether they would call the family in the middle of the night of low blood sugars unless they requested it.</p> <p>During an interview on 6/3/13 at 4:45 p.m. with RN #6, she indicated the "Even if in middle of night, I would notify family of low blood sugars as I try to put myself in their place if it was my mom."</p> <p>On 6/4/13 at 3:00 p.m., RN #1 presented a copy of the facility's current policy titled "Notifications". Review of this policy at this time time included, but was not limited to: "Policy: staff informs the patient,</p>			

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	<p>consults with their attending physician, and notifies the patient's surrogates when:...A significant occurs in the patient's physical, mental or psychosocial status; treatment needs to be altered significantly...Rationale: Patients, families and/or responsible parties have the right to be notified of changes in the patient's physical, mental or psychosocial status, treatment plan..."</p> <p>B. Review of the nursing notes between 3/7/13 and 3/16/13, the following entries were noted: - "3/13/13 1225 [12:25 p.m.] - Summoned to resident room by family. entering room, resident abd [abdomen] [with] racking motion, Bil [bilateral] leg [with] movement also noted...episodes lasting 5-7 minutes. [family member] states 'she did this again before you got here. I want the doctor called now. I have never seen anything like that'..."</p> <p>- "3/13/13 1245 [12:45 p.m.] - Resident having jerking motion of trunk and legs. Family at bedside. VSS. [vital signs stable]."</p> <p>- "3/13/13 1745 [5:45 p.m.] - No further jerking motions of body noted</p>			

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	<p>since family left at 1400. Has cont to be A & O x 3 [alert and oriented times 3]."</p> <p>- "3/14/13 2 AM - ...cont to offer fluids and snacks, appetite poor, takes one bite and falls asleep..."</p> <p>- "3/14/13 1730 [5:30 p.m.] - ...CXR [chest x-ray] and UA [urinalysis] [with] C & S [culture and sensitivity] ordered. Family notified. [name of family member] not content [with] MD [physician] orders. Requested BMP [basic metabolic profile] r/t [related to] muscle twitching."</p> <p>- "3/16/13 1200 [noon] - ...Had 2 episodes of jerking motion to right arm, rolling action of abdomen and jerking of bil legs. Is alert and oriented x 3 during episodes. Numerous family members at bedside today, had 4 episodes of small liquid emesis. 1710 - MD notified of Ultrasound results and that resident had urinary retention and jerking movement of right arm."</p> <p>3/16/13 SBAR communication form/progress note [a form in which vital signs, symptoms, problems observed to be relayed to the physician] completed at 19:35 - "CNA summoned nurse into resident's room</p>			

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	<p>- observed resident to be making "seizure like" activity. Unit manager requested to help with assessment - turned resident on side - juice that resident appeared to have been drinking drained out. Res unresponsive to nurse, o2 sat [amount of oxygen in the blood] obtained at 74% on 2 l/m. A code was called, another nurse was requested to call 911. Crash cart used. Placed res on nonrebreather mask at 10 L [liter] with sats improving to 84%. BS obtained at 106. Res observed making gurgling sounds, skin grayish-blue. EMS [emergency medical services] entered room and took over care - transferred to [name of hospital] emergency room for eval [evaluation] - 2235 admitted with a seizure diagnosis."</p> <p>During the interview with the responsible party on 6/3/13 at 3:18 p.m., she indicated that when the resident first began experiencing the episodes of jerking movements on 3/13/13, both she and the other family members had requested the resident be seen by a neurologist as soon as possible. She indicated that the family had made the request for several days until the nursing staff had finally contacted the primary physician on 3/16/13 for a referral to see a</p>			

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	<p>neurologist.</p> <p>This Federal tag is related to Complaint IN00128175.</p> <p>3.1-5(a)(2)</p>				

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F000203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone</p>						

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	<p>number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interviews, the facility failed to ensure a Transfer Sheet which listed the reason for the transfer, the effective date of the transfer, and the location of where the resident was being transferred to, accompanied the resident to the hospital. This deficient practice affected 1 of 3 residents reviewed for hospital transfers. (Resident #B)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident had diagnoses which included, but were not limited to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p>	F000203	<p>I. Resident B is no longer a resident of the facility. II. All residents have potential to be affected. A chart audit of all hospital transfers for the past 30 days was completed to validate a completed transfer sheet was included in the hospital transfer. III. The SDC or designee will in-service all licensed nurses on FRM 67300 Resident Transfer Form completion. IV. The Director of Nursing or designee will audit hospital transfers for transfer form completion 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee. V. Date of Completion: July 5, 2013</p>	07/05/2013

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	<p>On 3/16/13, Resident #B was sent to the emergency room due to continuous seizures. Documentation was lacking of the facility having sent a Transfer Sheet with the resident when she had been transferred.</p> <p>During interviews with RN #5 on 5/30/13 at 11:15 a.m., LPN #9 at 11:20 a.m., and LPN #1 at 11:30 a.m., they indicated the Transfer Sheet was always part of the transfer packet when a resident went to the hospital.</p> <p>During an interview with the Administrator on 6/4/13 at 9:00 a.m., she indicated that after doing a complete chart audit the night before, she was unable to locate the transfer packet which should have contained the Transfer Sheet. She indicated a copy of all paperwork sent with the resident to the hospital should have been left on the clinical record.</p> <p>This Federal tag is related to Complaint IN00128175.</p> <p>3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(E) 3.1-12(a)(9)(G)</p>			

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F000205 SS=D	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure the facility's bed-hold was sent with the resident when transferred to the hospital. This deficient practice affected 1 of 3 residents reviewed for paperwork upon transfer to the hospital. (Resident #B)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident had diagnoses which included, but were not limited</p>	F000205	I. Resident B is no longer a resident of the facility. II. All residents have potential to be affected. A chart audit of all hospital transfers for the past 30 days was completed to validate a Notice of Bed Hold Policy was included in transfer discrepancy has been corrected with immediate family/responsible party notification and copy of Bed Hold Policy. III. The SDC or designee will in-service all licensed nurses on FRM 67303 Notice of Bed Hold Policy completion. IV. The Director of Nursing or designee will audit hospital transfers 5 times a week	07/05/2013

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	<p>to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p> <p>On 3/16/13, Resident #B was sent to the emergency room due to continuous seizures. Documentation was lacking of the facility's bedhold having been sent with the resident when she had been transferred.</p> <p>During interviews with RN #5 on 5/30/13 at 11:15 a.m., LPN #9 at 11:20 a.m., and LPN #1 at 11:30 a.m., they indicated the Bedhold Policy was always part of the transfer packet when a resident went to the hospital.</p> <p>During an interview with the Administrator on 6/4/13 at 9:00 a.m., she indicated that after doing a complete chart audit the night before, she was unable to locate the transfer packet which should have contained the Bedhold policy. She indicated a copy of all paperwork sent with the resident to the hospital should have been left on the clinical record.</p> <p>On 6/5/13 at 9:20 a.m., RN#1 presented a copy of the facility's current policy titled "Bed-hold & Readmission". Review of this policy at</p>		<p>for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee. V. Date of Completion: July 5, 2013</p>		

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	<p>this time included, but was not limited to: "Policy: The bed-hold policy is given to the patient ...at the time of transfer or temporary discharge. Compliance Guidelines:...2. When an emergency transfer is initiated, the notice is provided to the patient, surrogate, or representative upon transfer. The written notice may be included in the papers sent with the patient to the hospital..."</p> <p>This Federal tag is related to Complaint IN00128175.</p> <p>3.1-12(a)(25) 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)</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 interviews, the facility failed to ensure physician's orders were followed for hypoglycemic monitoring for 1 of 3 residents reviewed for blood sugar monitoring and for discontinuing a pain medication for 1 of 1 resident reviewed for pain management. (Residents #B and #J)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident was admitted to the facility from the hospital on 3/7/13 and had diagnoses which included, but were not limited to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p> <p>Review of the admitting physician orders indicated they were signed by the physician on 3/14/13, but the 3/7/13 nursing admit note indicated the orders were verified and confirmed with him on admission.</p>	F000282	<p>I. Resident B is no longer a resident of the facility. Resident J pain medication has been discontinued.</p> <p>II. All residents have potential to be affected. An audit of all hypoglycemic monitoring physician orders has been completed for transcription accuracy and compared to current blood glucose results to validate physician orders are completed as ordered any discrepancy has been corrected with immediate physician and family/responsible party notification. A three way audit of physician order to Medication Administration Record to cart content has been completed on all active resident charts in the facility any discrepancy has been corrected with immediate physician and family/responsible party notification.</p> <p>III. The SDC or designee will in-service all licensed nurses on medication discontinuation order transcription; PRO 62000-15 Renewed or Recapitulated Physician's Orders, Medication Records, and Treatment Records; and PRO 62000</p>	07/05/2013			

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	<p>The admitting orders included, but were not limited to: "Hypoglycemic Treatment Order, if applicable: follow center protocol - check blood glucose every 15 minutes, until blood sugar is over 70.</p> <ul style="list-style-type: none"> - If unable to take po [by mouth], give 1 mg of Glucagon IM [intra- muscular] - max IM/IV dose 1 mg - repeat in 20 minutes, may utilize medication E-kit supplies, notify physician. - if able to take po, provide oral carbohydrates according to 15/15 rule; repeat in 15 minutes PRN [as needed]. Give additional snack if more than 1 hours to next meal." <p>On 6/3/13 at 9:35 a.m., Administrator #1 presented a copy of the facility's current policy titled "Blood Glucose Monitoring Using a Nova Stat Strip Glucometer". Review of this policy at this time included, but was not limited to:...</p> <ul style="list-style-type: none"> c. patient unresponsive - give 1 ampule (50 ml) [milliliters] of 50% dextrose IV [Intravenous]. d. check blood glucose every 15 minutes, until blood sugar is over 70 mg/dl. If 15 min [minutes] after treatment shows continued hypoglycemia, treatment should be repeated. e. If blood sugar continues to fall after 15 minutes or continues to be below 70 mg/dl after 30 minutes, call physician. 41. If blood sugar remains less than 70 		<p>Physician Orders.</p> <p>IV. The Director of Nursing or designee will audit transcription of all new physician orders 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Two nurses will complete month-end Renewed or Recapitulated Physician's monthly for 3 months. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V. Date of Completion: July 5, 2013</p>		

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	<p>mg/dl, notify the physician and follow the physician's order as applicable..."</p> <p>Review of the nursing notes between 3/7/13 and 3/16/13, the following notations were made:</p> <ul style="list-style-type: none"> - "3/13/13 4 am - went to check on resident, res [resident] cont [continues] to be groggy, opens eyes when spoken to, but mumbles speech, re-checked BS [blood sugar] 42, call to [name of physician], new order to give Dextrose 50 one amp, hold Glipermide [a diabetic medication] today and decrease to 2.5 mg daily." The next documented BS reading was at 6 A.M. - 2 hours after the first reading. Documentation was lacking of the blood sugar being monitored every 15 minutes until it reached over 70 during those 2 hours. - "3/13/13 6 AM - IV access obtained...Dextrose 50 1 amp given IV push, BS at this time 56..." The next documented blood sugar reading was at 6:30 a.m. - "3/13/13 1630 [4:30 p.m.] - Accucheck 50 - given oj with 2 packs of sugar added and given to resident." - "3/13/13 1730 [5:30 p.m.] - Accucheck 50 - encouraged to drink 			

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	<p>other half of previous glass of oj." The next documented blood sugar reading was at 9:00 p.m. in which the reading was 64. Juice and nutritional supplement were given, but documentation was lacking of any additional blood sugar readings until 30 minutes later.</p> <p>- "3/13/13 2130 [9:30 p.m.] BS 57 - oj [orange juice] given - no apparent distress noted. No involuntary movements noted. Will continue to observe." The next documented blood sugar reading was at 2 A.M. on 3/14/13.</p> <p>- "3/14/13 2 am - BS 67 continue to offer food and fluids." The next documented blood sugar reading was at 7:00 a.m. No additional blood sugar readings were documented until 3/15/13 at 7:00 a.m..</p> <p>- "3/16/13 0200 [2:00 a.m.] - res BS 68 - OJ given at resident request. At 0230 [2:30 a.m.] BS was up to 99."</p> <p>Documentation was lacking of the nursing staff monitoring the resident's blood sugars every 15 minutes and offer snacks until the blood sugars reached over 70 during hypoglycemic reactions.</p>			

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	<p>2. Review of the clinical record for Resident #J on 6/5/13 at 9:30 a.m. indicated the resident had diagnoses which included, but were not limited to: osteoporosis and disc degeneration.</p> <p>On 2/17/13, a new order was received for Ibuprofen 400 milligrams [mg] - 1 tablet BID [twice a day] due to pain in her right leg.</p> <p>On 2/18/13, a new order was received to discontinue the Ibuprofen.</p> <p>Review of the February, March, and April MARs reflected the medication order was still being printed on it but was marked off as being discontinued. The May MAR still contained the medication order and was not marked off as being discontinued.</p> <p>The June MAR again reflected the medication order and on 6/1/13 and 6/5/13, resident was given Ibuprofen due to knee pain. Review of the monthly physician orders for May and June failed to locate an order.</p> <p>On 6/5/13 12:20 p.m. during a discussion with the Director of Nursing [DoN], the DoN indicated</p>			

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	<p>"They go off the prior months' MARs when doing the next month's and then check the re-writes [monthly physician orders] for any additional orders. Since they did not see on the prior MAR the Ibuprofen as being marked out in May, it got written on for June. Obviously they did not check the re-writes close enough. We print off the new MARs here. I called the Pharmacy and they said they never received the order to discontinue the medication which was why they went ahead and sent it."</p> <p>LPN #2 was also present at this interview with the DoN. She indicated "When the resident complained of pain, I looked at the MAR and saw she had a PRN [as needed] Ibuprofen order but no medication in the cart. So I called pharmacy and had them bring it."</p> <p>This Federal tag is related to Complaint IN00127672.</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 record review and interviews, the facility failed to assess a dialysis resident's shunt site for pain, condition of skin, and thrill/bruit after each dialysis return. This deficient practice affected 1 of 1 dialysis resident reviewed for shunt site condition and overall status (Resident #D). The facility also failed to monitor and provide physician ordered interventions when a resident's blood glucose readings fell below set parameters. This deficient practice affected 1 of 3 residents reviewed for blood glucose monitoring (Resident #B).</p> <p>Finding includes:</p> <ol style="list-style-type: none"> Review of the clinical record for Resident #D on 6/4/13 at 4:00 p.m., indicated the resident had diagnoses which included, but were not limited to: chronic kidney disease stage 4, coronary atherosclerosis unspecified vessel, hypertension. 	F000309	<p>I. Resident B is no longer a resident of the facility. Resident D has had a dialysis access site assessment completed.</p> <p>II. All residents monitored for blood glucose readings and all residents receiving dialysis services have potential to be affected. An audit of all blood glucose readings has been completed to validate all hypoglycemic readings have received prompt follow-up per policy any discrepancy has been corrected with immediate physician and family/responsible party notification. An audit of all residents receiving dialysis, Dialysis Logs, has been completed and all residents receiving dialysis have had a dialysis access site assessment completed.</p> <p>III. The SDC or designee will in-service all licensed nurses on PRO 63003-01 Blood Glucose Monitoring Using a Nova Stat Strip Glucometer section Hypoglycemia; PRO 66204 Hemodialysis with focus on FRM</p>	07/05/2013	

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	<p>Review of the May 2013 monthly physician orders indicated the resident had an order dated 3/11/11 for "Complete V/S [vital signs] when patient returns from dialysis."</p> <p>A second order dated 8/29/11 also indicated "Check BP only post dialysis days on Tuesday, Thursday, Saturday."</p> <p>Review of the "Dialysis Log" for March, April and May 2013 indicated the following days were lacking an assessment of the resident upon return from the dialysis center: [assessment included: vital signs, dialysis site care, access site for signs and symptoms of infection and thrill/bruit present, post-dialysis sessions checking shunt site for bleeding, pain swelling, redness every hours for 6 hours):</p> <ul style="list-style-type: none"> - March - 3/12, 3/14, 3/23, 3/26, and 3/30. - April - 4/2, 4/11, 4/18, 4/20, 4/25, and 4/30 - May - 5/2, 5/7, 5/9, 5/14, 5/16, 5/21, and 5/25 <p>Review of the 1/17/13 Care Plan on "Alteration in Renal Function/Need for Hemodialysis" listed among the approaches as "Dialysis Log", "Monitor R [right] AV Fistula {arterial</p>		<p>66204 Dialysis Log.</p> <p>IV. The Director of Nursing or designee will audit blood glucose readings to validate follow-up on all readings outside parameters in policy or ordered by physician 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee. The Director of Nursing or designee will audit transcription accuracy of all new physician orders 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V.</p> <p>I. Resident B is no longer a resident of the facility. Resident D has had a dialysis access site assessment completed.</p> <p>II. All residents monitored for blood glucose readings and all residents receiving dialysis services have potential to be affected. An audit of all blood glucose readings has been completed to validate all hypoglycemic readings have received prompt follow-up per policy any discrepancy has been corrected with immediate physician and family/responsible</p>		

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	<p>venous] for bruit, infection".</p> <p>During an interview on 6/4/13 at 3:50 p.m. with LPN #6, she indicated "We will check her vitals a bit after she returns as she likes her quiet time when she first comes back and her coffee. So about 4PM, I take her coffee in and check on how she is doing. The pressure dressing - in the morning, she asks us to clean the shunt site, and we'll document for 3 days if any bruising or issues are noted. Shunt site is not monitored daily unless on the 3 day charting."</p> <p>On 4/16/13, a memo from dialysis center dietitian indicated "Please send patient double meat portions due to low albumin." - Lab from dialysis center indicated the resident's albumin level to be 3.7 when the target goal needed to be 4 or higher. (protein in the blood that helps fight infections and aids in healing).</p> <p>Review of the 8/2/12 care plan on "I have increased nutritional risk: related to intakes. I have Chronic Renal Failure." A review date of 2/12/13 was also documented. No further updates to the care plan after 2/12/13 could be located to reflect this recommendation.</p>		<p>party notification. An audit of all residents receiving dialysis, Dialysis Logs, has been completed and all residents receiving dialysis have had a dialysis access site assessment completed.</p> <p>III. The SDC or designee will in-service all licensed nurses on PRO 63003-01 Blood Glucose Monitoring Using a Nova Stat Strip Glucometer section Hypoglycemia; PRO 66204 Hemodialysis with focus on FRM 66204 Dialysis Log.</p> <p>IV. The Director of Nursing or designee will audit blood glucose readings to validate follow-up on all readings outside parameters in policy or ordered by physician 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee. The Director of Nursing or designee will audit transcription accuracy of all new physician orders 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V. Date of Completion: July 5, 2013</p>				

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	<p>The last Dietitian note on Resident #D was dated 4/9/13.</p> <p>On 6/4/13 at 5:20 p.m., the Dietary Manager indicated "The dietitian is the one who would do the documentation on dialysis center dietitian's requests/recommendations and then would come and tell me what to implement. She comes in Monday, Wednesday, and Fridays."</p> <p>On 6/4/13 at 3:55 p.m., RN #1 presented a copy of the facility's current policy titled "Residents Receiving Dialysis". Review of this policy at this time included, but was not limited to: "...1. Registered Dietitian evaluates resident's nutrition, hydration needs and/or nutrition/hydration restrictions as it relates to the resident's end-stage renal disease. 2. Licensed nurses evaluate the resident for signs and symptoms of infection/bacteremia, bleeding/hemorrhage, septic shock and/or excess/deficient fluids. 3. Licensed nurses manage dialysis access site to maintain patency and adequate blood flow for dialysis...10. Registered Dietitian educates the resident and/or family/significant other on nutrition and hydration needs and rationale for restrictions, if applicable. 11. Plan of care include directives for</p>			

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	<p>managing the resident's needs..."</p> <p>2. Review of the clinical record for Resident #B on 5/29/13 at 3:55 p.m., indicated the resident was admitted to the facility from the hospital on 3/7/13 and had diagnoses which included, but were not limited to: recurrent pneumonia, diabetes mellitus, chronic interstitial lung disease, obstructive sleep apnea, and hypertension.</p> <p>Review of the admitting physician orders indicated they were signed by the physician on 3/14/13, but the 3/7/13 nursing admit note indicated the orders were verified and confirmed with him on admission.</p> <p>The admitting orders included, but were not limited to: "Hypoglycemic Treatment Order, if applicable: follow center protocol - check blood glucose every 15 minutes, until blood sugar is over 70.</p> <ul style="list-style-type: none"> - If unable to take po [by mouth], give 1 mg of Glucagon IM [intra- muscular] - max IM/IV dose 1 mg - repeat in 20 minutes, may utilize medication E-kit supplies, notify physician. - if able to take po, provide oral carbohydrates according to 15/15 rule; repeat in 15 minutes PRN [as needed]. Give additional snack if 			

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	<p>more than 1 hours to next meal."</p> <p>On 6/3/13 at 9:35 a.m., Administrator #1 presented a copy of the facility's current policy titled "Blood Glucose Monitoring Using a Nova Stat Strip Glucometer". Review of this policy at this time included, but was not limited to:...c. patient unresponsive - give 1 ampule (50 ml) [milliliters] of 50% dextrose IV [Intravenous]. d. check blood glucose every 15 minutes, until blood sugar is over 70 mg/dl. If 15 min [minutes] after treatment shows continued hypoglycemia, treatment should be repeated. e. If blood sugar continues to fall after 15 minutes or continues to be below 70 mg/dl after 30 minutes, call physician. 41. If blood sugar remains less than 70 mg/dl, notify the physician and follow the physician's order as applicable..."</p> <p>Review of the nursing notes between 3/7/13 and 3/16/13, the following notations were made: - "3/13/13 4 am - went to check on resident, res [resident] cont [continues] to be groggy, opens eyes when spoken to, but mumbles speech, re-checked BS [blood sugar] 42, call to [name of physician], new order to give Dextrose 50 one amp, hold Glipermide [a diabetic medication] today and decrease to</p>			
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	<p>2.5 mg daily." The next documented BS reading was at 6 A.M. - 2 hours after the first reading. Documentation was lacking of the blood sugar being monitored every 15 minutes until it reached over 70 during those 2 hours.</p> <p>- "3/13/13 6 AM - IV access obtained...Dextrose 50 1 amp given IV push, BS at this time 56..." The next documented blood sugar reading was at 6:30 a.m.</p> <p>- "3/13/13 1630 [4:30 p.m.] - Accucheck 50 - given oj with 2 packs of sugar added and given to resident."</p> <p>- "3/13/13 1730 [5:30 p.m.] - Accucheck 50 - encouraged to drink other half of previous glass of oj." The next documented blood sugar reading was at 9:00 p.m. in which the reading was 64. Juice and nutritional supplement were given, but documentation was lacking of any additional blood sugar readings until 30 minutes later.</p> <p>- "3/13/13 2130 [9:30 p.m.] BS 57 - oj [orange juice] given - no apparent distress noted. No involuntary movements noted. Will continue to observe." The next documented blood sugar reading was at 2 A.M. on</p>			

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	<p>3/14/13.</p> <p>- "3/14/13 2 am - BS 67 continue to offer food and fluids." The next documented blood sugar reading was at 7:00 a.m. No additional blood sugar readings were documented until 3/15/13 at 7:00 a.m..</p> <p>- "3/16/13 0200 [2:00 a.m.] - res BS 68 - OJ given at resident request. At 0230 [2:30 a.m.] BS was up to 99."</p> <p>Documentation was lacking of the nursing staff monitoring the resident's blood sugars every 15 minutes and offer snacks until the blood sugars reached over 70 during hypoglycemic reactions.</p> <p>This Federal tag is related to Complaint IN00128175</p> <p>3.1-37(a)</p>				

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F000425 SS=A	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure a discontinued medication was removed from the medication refrigerator for 1 of 2 medication rooms reviewed, and 1 of 37 residents residing on the 300 hall and 400 hall. (Resident #48)</p> <p>Findings include:</p> <p>During a medication room observation, on 6/3/13, at 2:00 p.m., with LPN #7, the refrigerator for the 300 hall and 400 hall was observed to contain 1 bottle of Omeprazole 2</p>	F000425	<p>I. Resident 48 discontinued medication was immediately removed and disposed of.</p> <p>II. All residents have potential to be affected. A three way audit of physician order to Medication Administration Record to cart/medication room content has been completed on all active resident charts in the facility any discontinued medication has been immediately removed and disposed of/returned to pharmacy timely.</p> <p>III. The SDC or designee will in-service all licensed nurses on</p>	07/05/2013			

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	<p>milligrams/milliliter suspension with an expiration date of 5/4/13. LPN #7 indicated that this medication had been discontinued for Resident #48 and did not know why it was still in the refrigerator. She indicated that it should have been removed from the refrigerator, marked as discontinued and placed in the container with other discontinued or returned medications.</p> <p>A review of the physician's recapitulated orders, on 6/3/13, at 3:15 p.m., indicated the Omeprazole was ordered on 3/20/13, for a diagnosis of Gastroesophageal reflux disease, and was discontinued on 4/17/13.</p> <p>A policy for "Medication Discontinuation and Return to Pharmacy" provided by RN #1, on 6/4/13, at 9:35 a.m., and identified as their current policy, indicated "If a prescriber discontinues a medication and it is unlikely to be reordered within (seven) days, mark the medication container as discontinued...Remove the discontinued medication from the medication cart and/or medication room...Store medications awaiting disposal or return in a locked secure area designated for that purpose until destroyed or picked up by</p>		<p>PRO 62000-09 Medication Discontinuation and Return to Pharmacy.</p> <p>IV. The Director of Nursing or designee will audit all new physician discontinuation of medication orders and follow-up medication is disposed of/returned to pharmacy timely 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V. Date of Completion: July 5, 2013</p>				

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	<p>pharmacy...Complete pharmacy form for returning discontinued medications to the pharmacy and any state specific forms as required by law if applicable. Examples of information that may be required include: a. Date returned b. Nurse's or other responsible person's initials or signature c. Resident's name d. Name, strength and form of medication e. Prescription (Rx) number f. Quantity returned."</p> <p>3.1-25(o) 3.1-25(r)</p>			

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F000441 SS=D	<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 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.</p> <p>Based on interview and record review, the facility failed to implement</p>	F000441	I. Resident 64 received TB skin test.	07/05/2013			

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	<p>their infection control policy related to TB skin testing for 1 of 5 residents reviewed for TB skin test screening (Resident #64).</p> <p>Findings include</p> <p>1. Review of the medical record on 6/3/13 at 4:30 p.m. for Resident #64 indicated a TB skin test was not given in 2013. The last TB skin test was given on 4/9/12 and read on 4/12/12. An interview with RN #1 on 6/4/13 at 8:58 a.m. indicated the resident had not had a TB skin test in April 2013. She indicated the resident was given a skin test on 6/3/13 evening after being informed the TB skin test was not given.</p> <p>A copy of the policy and procedure for Tuberculin skin testing, provided by RN #1 on 6/5/13 at 9:00 a.m., indicated the TB skin test should be given to all employees and newly admitted residents unless contraindicated. The policy also indicated the test results should be documented on the designated form in the residents medical record.</p> <p>3.1-18(e)</p>		<p>II. All residents have potential to be affected. A chart immunization record TB skin test audit was completed on all active charts any discrepancy was corrected immediately with administration of TB skin test for residents with no contraindications.</p> <p>III. The SDC or designee will in-service all licensed nurses on PRO 68200-01 Mantoux Tuberculin Skin Test (TST).</p> <p>IV. The Director of Nursing or designee will audit immunization record TB skin test on all new, readmitted residents 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Audit results will be reviewed in monthly PI meeting to achieve 100% compliance as determined by PI committee.</p> <p>V. Date of Completion: July 5, 2013</p>				

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure Medication Administration Records [MARs] accurately reflected the current medication orders to avoid the resident from receiving a medication without a physician's order. This deficient practice affected 1 of 10 residents reviewed for unnecessary drugs (Resident #J).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #J on 6/5/13 at 9:30 a.m. indicated the resident had diagnoses which included, but were not limited to: osteoporosis and disc degeneration.</p> <p>On 2/17/13, a new order was received</p>	F000514	<p>I. Resident J pain medication has been discontinued on the current MAR and electronic system.</p> <p>II. All residents have potential to be affected. A three way audit of physician order to Medication Administration Record to cart content has been completed on all active resident charts in the facility any discrepancy has been corrected with immediate physician and family/responsible party notification.</p> <p>III. The SDC or designee will in-service all licensed nurses on PRO 62000-15 Renewed or Recapitulated Physician's Orders, Medication Records, and Treatment Records. The Medical Records Supervisor will complete RCS Physician Order Training Modules and pass related exams.</p>	07/05/2013			

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	<p>for Ibuprofen 400 milligrams [mg] - 1 tablet BID [twice a day] due to pain in her right leg.</p> <p>On 2/18/13, a new order was received to discontinue the Ibuprofen.</p> <p>Review of the February, March, and April MARs reflected the medication order was still being printed on it but was marked off as being discontinued. The May MAR still contained the medication order and was not marked off as being discontinued.</p> <p>The June MAR again reflected the medication order and on 6/1/13 and 6/5/13, resident was given Ibuprofen due to knee pain. Review of the monthly physician orders for May and June failed to locate an order.</p> <p>On 6/5/13 12:20 p.m. during a discussion with the Director of Nursing [DoN] and LPN #2, LPN #2 indicated that "When we get an order to discontinue a medication, you draw a line through on the MAR in yellow to highlight it out and indicate the date it was discontinued."</p> <p>The DoN indicated "They go off the prior months MARs when doing the next month's and then check the</p>		<p>IV. The Director of Nursing or designee will audit transcription of all new physician orders 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days. Two nurses will complete month-end Renewed or Recapitulated Physician's Date of Completion: July 5, 2013</p>		

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	<p>re-writes [monthly physician orders] for any additional orders. Since they did not see on the prior MAR the Ibuprofen as being marked out in May, it got written on for June. Obviously they did not check the re-writes close enough. We print off the new MARs here. I called the Pharmacy and they said they never received the order to discontinue the medication which was why they went ahead and sent it."</p> <p>During the final exit meeting with the DoN, Administrator #2 and RN #1 on 6/5/13 at 4:50 p.m., the DoN indicated that because the facility printed their own MARs, the order should have been taken off and never appeared again on the MARs for March through June to cause confusion.</p> <p>This Federal tag is related to Complaint IN00127672.</p> <p>3.1-50(a)(2)</p>				