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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/15/2011 |
| NAME OF PROVIDER OR SUPPLIER WOODLANDS, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN47304 | | |
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| F0000 | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: July 11, 12, 13, 14 and 15, 2011</p> <p>Facility number: 000134 Provider number: 155229 AIM number: 100275430</p> <p>Survey team: Betty Retherford, RN TC Delinda Easterly, RN Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: SNF/NF: 87 Total: 87</p> <p>Census payor type: Medicare: 6 Medicaid: 65 Other: 16 Total: 87</p> <p>Stage 2 Sample: 34</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 22,</p> | F0000 | | | |

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011

FORM APPROVED

OMB NO. 0938-0391

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| | 2011 by Bev Faulkner, RN | | | | |

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| F0156 SS=B | <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: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> | | | | |

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| | <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 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.</p> | | | | |

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| | <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, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were provided detailed information as to why Medicare coverage was being terminated and were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 2 of 3 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 37 and 29)</p> <p>Findings include:</p> <p>1.) Review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 37 and 29 on 7/15/11 at 9:30 a.m., indicated the letters lacked the following information,</p> <p>a. Detailed information as to why Medicare coverage was being terminated.</p> | F0156 | <p>F-156 Resident #29 is deceased. Resident #37 detailed information as to why Medicare coverage was terminated has been sent via certified mail to the resident responsible part. Residents receiving Notice of Medicare Provider non-coverage letters have the potential to be affected. Going forward residents will be issued detailed correspondence, in lay terms, on letterhead when Medicare services are to be terminated. The facility will include a detailed notice in lay terms the reasons for termination from Medicare services along with the facility rates that could be charged to the resident for non-covered services. The Administrator or Business will review each notice prior to mailing. The Administrator or designee will monitor all notices issued weekly x 4 weeks, then 5 every 2 weeks x 8 weeks then, 5 every month for 3 months, quarterly until 100% compliance is attained and</p> | 08/08/2011 | |

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| | <p>b. Any charges the residents could be assessed as a result of Medicare cancellation.</p> <p>c. Facility rates that could be charged to the resident for non-covered services.</p> <p>During an interview with the Administrator and Health Information Management Director (HIMD) on 7/15/11 at 10:30 a.m., the HIMD indicated she had no additional information to provide related to the residents having received any of the above information.</p> <p>2.) Review of the current facility policy, titled "Individual Rights," provided by the DoN on 7/15/11, at 12:30 p.m., included, but was not limited to, the following:</p> <p>"In addition to basic human rights, the long term care resident has individual rights specific to institutional care. They include, but are not limited to:...</p> <p>...5. The right to be informed of any charges for services not covered under the Medicare or Medicaid program, private insurance carriers, or by the facility's basic per diem charge....</p> | | <p>maintained x 2 quarters. Audits will be submitted for inclusion in the P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | | |

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| F0242 SS=D | <p>...Violations of Individual Rights</p> <p>...3. Failure to disclose all cost and charges to the resident.</p> <p>4. Failure to provide the resident with advance notice of an increase/decrease in the resident's cost of services...."</p> <p>3.1-4(a) 3.1-4(f)(3)</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each residents' schedules and choices about their care were honored for 3 of 3 residents reviewed for choices and daily care schedules in a Stage 2 Sample of 34. (Resident #'s 96, 39, and 3)</p> <p>Findings include:</p> | F0242 | <p>F-242</p> <p>Resident#96 Preference for rising and going to bed is now being honored. Care Plan has been revised accordingly. Resident#39 Preference for coordinated attire that is free of food spillage and stains is being honored daily. Resident # 3 treatments are now being completed at the time of his choice. Any further treatments ordered will be provided per</p> | 08/08/2011 | |

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| | <p>1.) The clinical record for resident #96 was reviewed on 7/13/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, depression, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>An admission Minimum Data Set (MDS) Assessment, dated 6/2/11, indicated Resident #96 had no problems with memory or recall and was not cognitively impaired.</p> <p>During an interview on 7/12/11 at 9:40 a.m., Resident #96 indicated she did not choose what time she got up in the morning. She indicated staff would just come into the room and tell her it was "time to get up for breakfast." She indicated she would sometimes prefer to stay in bed longer but stated "I just try to go with the flow."</p> <p>The health care plan and social service notes for Resident #96 lacked any information related to the resident's preferred time to get up in the morning.</p> <p>2.) Resident #39's clinical record review was completed on 7/14/11, at</p> | | <p>resident time preference. Residents residing within the facility have the potential to be affected. Residents have been interviewed to determine if preferences are being honored. An in-service was conducted by S.D.C. and S.S.D. on 7/28/11 regarding the importance of honoring the preferences of the resident. Resident preferences will be reviewed at Care Plan Meetings and residents interviewed to ensure their choices are being honored. The Social Service Director will interview 5 residents 3x weekly for 4 weeks, then 1x weekly for 4 weeks then, every 2 weeks x 4 weeks, then monthly x 3 months then, quarterly until 100% compliance is attained and maintained x 2 quarters. Audits will be submitted for inclusion in the P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | | |

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| | <p>9:42 a.m.</p> <p>The resident had a 5/26/11, quarterly MDS [Minimum Data Set] assessment. The assessment indicated Resident #39 had moderate cognitive impairment related to decision making. The assessment indicated the resident needed extensive assistance of one for dressing.</p> <p>During an interview with the Resident #39's daughter on 7/12/11, 1:19 p.m., she indicated the resident has food down the front of her clothing 90 percent of times she visits. She indicated she visits mostly in the evenings and she frequently has to change the resident's clothes when she arrives. She indicated the staff do not coordinate the resident's clothes when they dress her. She indicated the resident's appearance was important to the resident prior to admission and the resident always made sure her clothes were coordinated.</p> <p>During an interview with the Social Services Director on 7/14/11 at 12:59 p.m., She indicated the resident's daughter had commented at a care plan meeting several months ago about the resident's clothes.</p> | | | | |

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| | <p>3.) The clinical record for Resident #3 was reviewed on 7/11/11 at 11:00 a.m..</p> <p>Resident #3's current diagnoses included, but were not limited to, diabetes mellitus, edema and gout.</p> <p>During an interview with Resident #3 on ,7/11/11 at 11:53 a.m., he indicated the nursing staff come in at 3:00 a.m., to wrap his legs and bring medications in for him to take. The resident indicated this was unacceptable to him and indicated it was difficult to get any sleep. The resident indicated it was "aggravating to get woke up so much."</p> <p>The clinical record for Resident #3 indicated a current physician's for the following,</p> <p>A. Apply 4 inch Ace elastic bandages, wrap both legs with gauze and Ace wraps from toes to knees every other day. The original date of the order was 8/7/10.</p> <p>B. Instill 4 drops of Debrox into the right ear and then lavage to remove ear wax using tepid water. The order date was 7/12/11.</p> <p>The July 2011 "Treatment</p> | F0242 | <p>F-242 Resident#96 Preference for rising and going to bed is now being honored. Care Plan has been revised accordingly. Resident#39 Preference for coordinated attire that is free of food spillage and stains is being honored daily. Resident # 3 treatments are now being completed at the time of his choice. Any further treatments ordered will be provided per resident time preference. Residents residing within the facility have the potential to be affected. Residents have been interviewed to determine if preferences are being honored. An in-service was conducted by S.D.C. and S.S.D. on 7/28/11 regarding the importance of honoring the preferences of the resident. Resident preferences will be reviewed at Care Plan Meetings and residents interviewed to ensure their choices are being honored. The Social Service Director will interview 5 residents 3x weekly for 4 weeks, then 1x weekly for 4 weeks then, every 2 weeks x 4 weeks, then monthly x 3 months then, quarterly until 100% compliance is attained and maintained x 2 quarters. Audits will be submitted for inclusion in the P.I.Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | 08/08/2011 | |

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| | <p>Administration Record" indicated the Ace wraps treatment was to have been completed at 5:00 a.m. The Debrox treatment was to have been completed at 4:30 a.m.</p> <p>During an interview with LPN #1 on 7/14/11 at 8:15 a.m., she indicated the night shift completed the wraps to Resident #3's legs. She further indicated the Debrox ear lavage treatments were completed at 4:30 am.</p> <p>During an interview with the DoN (Director of Nursing) on 7/14/11 at 8:40 a.m., when she was made aware of Resident #3 complaints that he was awakened for his legs to be wrapped and to receive medications, she indicated, the night shift probably completed the treatments at that time because that is the slowest time of the shift. She indicated the Debrox medication was probably initiated at that time of the morning because that was the time the medication arrived from the pharmacy.</p> <p>Review of a physician's progress note, dated 6/25/11 indicated, "called to see patient who developed extensive cellulitis left lower leg excoriated and several open areas on the surface with erythema (redness)</p> | | | | |

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| F0247 SS=A | <p>and increase warmth noted. Edema present to the left lower leg to the ankle, lesions worse compared to 6/24/11 when dressed and cleansed by nurse. He is alert and communicates."</p> <p>A quarterly Minimum Data Set Assessment, dated 6/11/11, indicated Resident #3 had no memory problems and no cognitive deficit.</p> <p>4.) Review of the current facility policy, titled "Individual Rights," provided by the DoN on 7/15/11, at 12:30 p.m., included, but was not limited to, the following:</p> <p>"In addition to basic human rights, the long term care resident has individual rights specific to institutional care. They include, but are not limited to:...</p> <p>...21. The right to participate in planning his/her care and treatment or change(s) in his/her care and treatment....</p> <p>3.1-3(u)(3)</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview,</p> | F0247 | 1. Interview with resident #91. resident stated he is pleased with | 08/08/2011 | |

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| | <p>the facility failed to ensure residents were notified of roommate change for 1 of 2 sampled residents reviewed for notification of roommate change in a Stage 2 Sample of 34. (Resident #91)</p> <p>Findings include:</p> <p>During an interview on 7/12/11 at 9:30 a.m., with Resident #91, he indicated he had a roommate change within the last 9 months. He indicated he had not been notified of the new roommate prior to the resident being placed in his room. He indicated "they just brought him in."</p> <p>The clinical record for Resident #91 was reviewed on 7/14/11 at 8:46 a.m.</p> <p>A Quarterly Review Minimum Data Set assessment (MDS), dated 4/19/11, indicated Resident #91 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident was not cognitively impaired.</p> <p>During an interview on 7/14/11 at 12:59 p.m., the Social Services Director indicated a resident with a BIMS of 8 or above is informed of roommate changes.</p> | | <p>his roommate and that he was a quiet man and a friend.2. Residents receiving a new roommate or roommate changes have the potential to be affected. Residents with roommate changes or new roommates in the last 30 days have been audited to ensure that proper documentation is in place.3. Residents or Health Care Representatives will be informed by the Social Services Director and documented in the S.S. notes when a new roommate or roommate change is pending. 4. Social Services Director will review all room changes and new admissions to ensure that proper notifications are in place 3 x weekly x 4 weeks, weekly x 4 weeks, every 2 weeks x 4 weeks, monthly x 3 months and the quarterly until 100% compliance is attained and maintained x 2 quarters. All audits are submitted for inclusion in the P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. 5. Completion Date: 8/8/11</p> | | |

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| | <p>During an interview on 7/15/11 at 8:15 a.m., the Administrator indicated the facility had no documentation to provide regarding the resident being notified of a roommate change.</p> <p>During an interview on 7/15/11 at 9:43 a.m., with LPN #3, she indicated Resident #91 had a roommate change on 2/26/11.</p> <p>Review of a current facility policy, dated 6/2010, titled "Transfer of Resident Within the Facility," provided by the DoN on 7/14/11 at 2:00 p.m., included, but was not limited to, the following:</p> <p style="padding-left: 40px;">"...Procedure:..</p> <p style="padding-left: 40px;">...4. Give the resident and/or the resident's representative an appropriate transfer notice within the required period of time..."</p> <p>Review of the current facility policy, titled "Individual Rights," provided by the DoN on 7/15/11, at 12:30 p.m., included, but was not limited to, the following:</p> <p>"In addition to basic human rights, the long term care resident has individual</p> | | | | | | |

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| F0253 SS=E | <p>rights specific to institutional care. They include, but are not limited to:...</p> <p>...26. The right to receive notice before the room or roommate of the resident is changed...."</p> <p>3.1-3(v)(2)</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure, resident bathrooms were properly maintained for 8 of 34 bathrooms observed (rooms 6, 8 12, 15, 19, 29, a shared bathroom between rooms 22 & 24, and a shared bathroom between rooms 25 & 27), and walls in resident's rooms were in good repair for 5 of 34 rooms observed. (rooms 6, 8, 15, 19, and 23)</p> <p>Findings include:</p> <p>During the environmental tour with the Maintenance Director on 7/14/11 at 2:05 p.m., the following concerns were identified,</p> <p>A.) The resident bathrooms had chipped paint, missing trim, missing cove base, loose cove base, holes</p> | F0253 | <p>F-253</p> <p>The chipped paint, missing trim, missing cove base, holes needing patching and painting, stained tiles and nails in walls have been repaired in bathrooms for rooms 6, 8, 12, 15, 19, 29, and shared bathrooms for rooms 22 & 24 and 25 & 27 have been repaired. Resident room 6, 8, 15, 19, and 23 have had wallpaper repaired or replaced, holes patched and painted, and discoloration on ceilings removed or painted. Resident rooms were inspected on 7/20/11 for needed repairs and repairs scheduled for completion. The Maintenance Director will add inspection of resident rooms and bathrooms to the weekly Preventive Maintenance Program and immediately schedule repairs as indicated.</p> <p>The Executive Director will monitor for needed repairs 3x weekly x 4 weeks, then 1x weekly x 4 weeks then, every 2 weeks x</p> | 08/08/2011 | |

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| | <p>not patched, holes patched and not painted, tiles stained and discolored, and nails in the walls for rooms 6, 8, 12, 15, 19, 29 and shared bathrooms for rooms 22 & 24 and 25 & 27.</p> <p>B). The residents' rooms walls had torn/missing wallpaper, holes not patched, holes patched and not painted, nails, mustard colored substance on ceiling and black discoloration on ceiling for rooms 6, 8, 15, 19, and 23.</p> <p>During an interview with the Maintenance Director on 7/14/11 at 3:15 p.m., he indicated he was aware of all of the above observed environmental concerns. He further indicated he had not had time to complete the repairs as yet.</p> <p>3.1-19(f)</p> | | <p>4 weeks, then monthly x 3 months then, quarterly until 100% compliance is attained and maintained x 2 quarters. Audits will be submitted for inclusion in the P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | | |

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| F0272 SS=D | <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident had an accurate assessment completed related to bladder incontinence for 1 of 3 residents reviewed for incontinence status in a Stage 2 Sample of 34.</p> | F0272 | <p>F-272 Resident #27 MDS was modified on 7/29/11 to reflect accurate information. Care plan reviewed and revised as needed on 7/28/11. Residents that are incontinent may be affected. An audit for incontinent residents was completed by Nursing Management on 7/29/11 to ensure accurate assessments</p> | 08/08/2011 | |

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| | <p>(Resident #27)</p> <p>Findings include:</p> <p>The clinical record for Resident #27 was reviewed on 7/12/11 at 9:00 a.m.</p> <p>Resident #27's current diagnoses included, but were not limited to, Schizophrenia and anxiety.</p> <p>During observation on 7/11/11 at 11:30 a.m., Resident #27 was sitting on her bed in her room. A strong odor was immediately noted. The odor was body odor and/or urine odor.</p> <p>During observation on 7/11/11 at 2:30 p.m., Resident #27 was in her room in her bed. A slight urine odor was noted in the room.</p> <p>During observation on 7/12/11 at 9:00 a.m., a strong urine odor and body odor was noted in the resident's room.</p> <p>Review of the shower record for May, June, and July 2011 indicated the resident had received showers twice weekly for all 3 months. The record indicated the resident received a sponge bath daily on the days she had not received a shower.</p> | | <p>completed related to urinary incontinence. Care Plans reviewed and updated as necessary by 8/5/11.</p> <p>MDS coordinator will review RITA documentation and Nursing documentation for bladder incontinence prior to the completion of each MDS and code per RAI guidelines to ensure accurate assessments are being completed.</p> <p>DON or designee will audit five residents MDS's 3x week for 4wks, then 1 x weekly for 4 weeks, then every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters to ensure accurate assessments are completed related to urinary incontinence. Audits will be submitted for inclusion of PI. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.</p> <p>Date of compliance is 8/8/11</p> | | |

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| | <p>The bladder flow sheet for the month of July indicated on July 10, the resident was continent of bladder. On July 11, day shift, the resident was incontinent of bladder 1 time on the day shift. On July 12, the resident was incontinent of bladder 1 time on the day shift.</p> <p>A Health care plan, dated 5/1/11, indicated the resident had a problem listed as, requires assist in completing ADL's due to weakness and episodes of incontinence. The goal for the health care plan was the resident will assist with dressing self daily thru next review. Approaches for this problem included: set up clothing and assist resident with dressing and undressing, set up personal hygiene products and assist with oral care, hair care, nail care, a.m. and p.m. care, perineal care, and assist with showers 2 times a week with partials on non-shower days, observe for changes in level of participation with ADL's (activities of daily living) and refer to therapy screening if needed.</p> <p>During an interview on 7/13/11 at 1:20 p.m., with LPN #4, the nurse assigned to care for Resident #27, she indicated the resident was able to take herself to the bathroom and she completed her own peri care. She</p> | | | | |

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| | <p>further indicated the resident did not always "do a good job" with her peri care.</p> <p>A quarterly Minimun Data Set (MDS) assessment, dated 6/8/11, indicated Resident # 27 required limited assistance from the staff for toilet use, dressing and bathing and the MDS indicated the resident was always continent of her bladder; a code of 0 was documented</p> <p>The monthly flow record, used to monitor bladder continence, for June 2011, for the reference period of the MDS June 2 thru June 8th indicated the resident was incontinent of bladder 10 times during the following dates and times,</p> <p>A. June 2, 1 time on night shift B. June 3, 1 time on day shift C. June 4, 3 times on evening shift and 2 times on night shift D. June 5, 1 time on night shift E. June 6, 1 time on day shift F. June 8, 1 time on evening shift</p> <p>During an interview on 7/14/11 at 3:00 p.m., with LPN #3, the Unit Manager who works on the unit where Resident # 27 lives, indicated the MDS information was taken directly from the monthly bowel and bladder</p> | | | | | | |

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| | <p>reports from the computer. She indicated the resident had been incontinent of bladder 10 times during the June reference period. She indicated the resident's MDS should have coded the resident as a 2 for frequently incontinent meaning 7 or more episodes or urinary incontinence, but at least one continent episode on the MDS. She indicated "0" for always incontinent was incorrect.</p> <p>3.1-31(d)</p> | | | | |

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| F0279 SS=D | <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 record review, observation, and interview, the facility failed to ensure a comprehensive health care plan was developed for 3 of 12 residents reviewed for comprehensive health care plan development in a Stage 2 sample of 34. (Resident #'s 96, 3, and 81.)</p> <p>Findings include:</p> <p>1.) The clinical record for resident #96 was reviewed on 7/13/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes</p> | F0279 | <p>F-279 Resident #96 was immediately assisted with oral care and a new oral assessment and pain assessment was completed on 7/27/11 in which resident denied pain. Gums were pink and moist with no inflammation noted. Resident was referred to Occupational Therapy for oral care. Resident's care plan was revised to reflect oral care on 7/18/11. Resident #81 had pain assessment conducted on 7/14/11 with no complaints noted. Care plan revised to reflect history of pain and location. Resident seen by Nurse Practitioner on 7/20/11. Care plan for resident # 3 was revised to reflect fluctuating edema in lower extremities.</p> | 08/08/2011 | | | |

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| | <p>mellitus, depression, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>An admission Minimum Data Set (MDS) Assessment, dated 6/2/11, indicated Resident #96 had no problems with memory or recall and was not cognitively impaired. The assessment indicated she required extensive assistance from one staff member for personal hygiene needs.</p> <p>During an interview on 7/12/2011 at 9:48 a.m., Resident #96 indicated her dentures had only been cleaned once in the last week. She indicated her natural teeth had not been brushed since she was admitted. She indicated she needed the assistance of the staff to set up supplies and assist her with brushing her teeth due to paralysis of one arm/hand.</p> <p>During an interview with the Director of Nursing and Resident #96 on 7/13/11 at 3:55 p.m., Resident #96 indicated she had only been given oral/dental care once since admission, which was done once by the dentist when she was seen by him earlier in the week.</p> <p>A health care plan problem, dated 6/13/11, indicated Resident #96</p> | | <p>Residents with comprehensive care plans have the potential to be affected. Residents care plans have been reviewed and updated to reflect resident's current medical status by 8/5/11. MDS coordinator will ensure that care plans reflect resident's current medical status. Resident orders and change of condition reviewed daily during morning meeting to assist in immediate identification of resident needs problems, goals, and treatments for care planning purposes. DON or designee will audit to ensure care plans reflect current medical status for 5 residents 3x weekly for 4weeks, then weekly for 4 weeks, then every two weeks for four weeks then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Date of compliance is 8/8/11</p> | | |

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| | <p>required assistance from the staff for completing all activities of daily living related to weakness, right hemiplegia, CVA.... One of the approaches for this problem was for staff to set up supplies and assist resident with oral care. The approaches for assistance with oral care did not indicate how often oral care was to be provided.</p> <p>2.) The clinical record for Resident #81 was reviewed on 7/13/11 at 9:30 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, congestive heart failure and hypertension.</p> <p>During an interview on 7/11/11 at 3:09 p.m., Resident #81 indicated she had a history of chronic back and leg pain. She indicated she was receiving routine pain medications, but they were not "holding her pain." She was observed during the interview to be making a rocking motion back and forth in her chair. She indicated this movement sometimes helped to relieve her back pain. She indicated it was not yet time for any more pain medication.</p> <p>Physician's orders, dated 7/3/11, indicated Resident #81 had an order for a Fentanyl patch 25 mcg/hr</p> | | | | |

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| | <p>(micrograms per hour) to be applied and changed every 3 days. The orders also indicated the resident could have Hydrocodone with acetaminophen (Norco-a narcotic pain medication) 5/325 mg (milligrams), one tablet two times a day as needed for moderate to severe pain and Zolpidiem Tartrate (Ambien-a hypnotic) 5 mgs at bedtime as needed for insomnia.</p> <p>An "Interim Care Plan" for Resident #81, dated 6/25/11, indicated she "has pain". The care plan lacked any information related to the type of pain and/or frequency of the pain. The care plan listed one intervention for the pain which was "Fentanyl patch (a narcotic pain patch) every 3 days". The care plan lacked any information of the resident having an order for an "as needed" pain medication.</p> <p>The "Interim Care Plan" for Resident #81, dated 6/25/11, lacked any information related to the resident having problems with insomnia and the possible need for a hypnotic medication.</p> <p>The Interim Care Plan was the only care plan noted in the clinical record.</p> <p>3.) The clinical record for Resident #3 was reviewed on 7/11/11 at 11:00</p> | | | | |

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| | <p>a.m..</p> <p>Resident #3's current diagnoses included but were not limited to, diabetes mellitus, edema and gout.</p> <p>The clinical record for Resident #3 indicated a current physician's for the following:</p> <p>Apply 4 inch Ace elastic bandages, wrap both legs with gauze and Ace wraps from toes to knees every other day. The original date of the order was 8/7/10.</p> <p>The July 2011 "Treatment Administration Record" indicated the Ace wraps treatment was to have been completed every other day.</p> <p>Review of a physician's progress note, dated 6/25/11, indicated "called to see patient who developed extensive cellulitis left lower leg excoriated and several open areas on the surface with erythema (redness) and increase warmth noted. Edema present to the left lower leg to the ankle, lesions worse compared to 6/24/11 when dressed and cleansed by nurse. He is alert and communicates."</p> <p>The health care plan for Resident #3</p> | | | | |

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| | <p>lacked any information related to the resident having a diagnosis of edema and or cellulitis which required the treatment of having the resident's lower extremities wrapped with Ace wraps every other day.</p> <p>During an Interview with the MDS coordinator, on 7/15/11 at 10:05 a.m., she indicated the resident did not have a health care plan related to edema and or cellulitis that required the treatment of applying the Ace wraps to his legs. She indicated the problem should have been care planned.</p> <p>4.) Review of the current facility policy, dated 12/08, titled "Resident Care Plan," provided by the DoN on 7/15/11, at 12:30 p.m., included, but was not limited to, the following:</p> <p>"Policy</p> <p>An interim care plan is to be completed upon admission.</p> <p>The individualized, interdisciplinary care plan is to be completed by participation of all disciplines and printed within 7 days of the RAI (Resident Assessment Instrument) completion, according to RAI guidelines.</p> | | | | |

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| NAME OF PROVIDER OR SUPPLIER WOODLANDS, THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN47304 | | |
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| | <p>Review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services.</p> <p>Resident Care Plan Definition:</p> <p>A brief written portrait of the resident and an individualized guide of the nursing care needed....</p> <p>...Essentials of an Overall Plan of Care:...</p> <p>...2. Identification of problems and needs...</p> <p>...4. Methods, approaches, or plan: description of what is actually going to be done for, to, or with the resident in order to achieve the goals....</p> <p>...6. Review & evaluation:</p> <p>a. This may state progress made and goals continued.</p> <p>b. May show no progress and change of approach.</p> <p>c. May show accomplishment of short term goal and new goal and approach.</p> | | | | |

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| F0280 SS=D | <p>7. Care plan identifies the patient/resident problem, where you are with a resident, where you are going (goals), and how you are going to get there (plan/approach)...."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review,</p> | F0280 | Completion Date: 8/8/11F-280 | 08/08/2011 | |

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| | <p>and interview, the facility failed to ensure health care plans were reviewed and updated. This affected 2 of 12 residents reviewed for health care plans in a Stage 2 Sample of 34. [Resident #'s 72 and 19]</p> <p>Findings include:</p> <p>1. Resident #72's clinical record review was completed on 7/14/11 at 2:00 p.m.</p> <p>The resident had quarterly MDS [Minimum Data Set] assessment, dated 12/10/10 and 3/9/11 and an annual MDS assessment dated 6/8/11.</p> <p>The resident's health care plan indicated the last health care plan conference for the resident was on 1/13/10.</p> <p>The target dates for the care plan problem goals were dated 6/11.</p> <p>During an interview with the Director of Nursing and Administrator on 7/14/11 at 4:00 p.m., additional information was requested related to the lack of current health care plan reviews for Resident #72.</p> <p>The facility failed to provide any</p> | | <p>A care plan conference was held for resident #72 8/3/11 in which resident was present. Care plan was revised to reflect current medical status. Resident # 19 was screened by therapy in which Occupational therapy requested an evaluation. Resident was evaluated on 7/29/11with a plan of care implemented to address contracture management. Residents that have a comprehensive care plan in place have the potential to be affected. An audit was completed by Nursing Management on 8/5/11 to ensure care plans were updated timely to reflect residents current medical status. There is a calendar in place to identify those residents due for Care Plan review and update. The calendar is provided to the IDT at the beginning of each month and will be reviewed for timeliness and completion daily at Morning Stand-up meeting. DON or designee will audit 5 residents, 3x per week for 4wks, then 1x weekly for 4 weeks, then every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters to ensure that care plans are reviewed and updated timely. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.</p> | | |

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| | <p>additional information as of exit on 7/15/11.</p> <p>2.) The clinical record for Resident #19 was reviewed on 7/12/11 at 2:30 p.m.</p> <p>Resident #19's current diagnoses included, but were not limited to, osteoarthritis and generalized weakness.</p> <p>During observation on 7/11/11 at 4:00 p.m., Resident #19 was observed in her wheelchair in her room. Her head was tilted to one side.</p> <p>During observation on 7/13/11 at 2:15 p.m., the resident was observed in a wheelchair in her room. The resident's eyes were closed. Her head was tilted to one side, to almost her shoulder area.</p> <p>A health care plan, dated 6/11, indicated the resident had a problem listed as, has contractures to neck and is at risk for further contractures related to decreased mobility, diagnosis of osteoarthritis and degenerative joint debility, approaches for this problem included, restorative to do AROM,(active range of motion) exercises, observe for progression of contractures and report to physician, therapy to screen</p> | | | | |

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| | <p>quarterly and as indicated, encourage to and assist with repositioning every 2 hours and as needed and handle resident gently during care and report signs and symptoms of pain to nurse.</p> <p>An annual Minimum Data Set Assessment, dated 6/30/11, indicated the resident had impairment on both sides with ROM (range of motion) of the upper extremities (shoulder, elbow, wrist, hand).</p> <p>During an Interview with the DoN on 7/13/11 at 4:00 p.m., she indicated the facility had no record of the resident having had any restorative nursing services. She indicated the facility had no record of any AROM exercises having been completed. She further indicated she was not sure if the resident could tolerate any of the exercises and the nursing staff would have to re-evaluate the resident's contractures and the need for restorative nursing.</p> <p>3.) Review of the current facility policy, dated 12/08, titled "Resident Care Plan," provided by the DoN on 7/15/11, at 12:30 p.m., included, but was not limited to, the following:</p> <p>"Policy</p> | | | | |

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| | <p>An interim care plan is to be completed upon admission.</p> <p>The individualized, interdisciplinary care plan is to be completed by participation of all disciplines and printed within 7 days of the RAI completion, according to RAI guidelines.</p> <p>Review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services...</p> <p>...6. Review & evaluation:</p> <p style="padding-left: 40px;">a. This may state progress made and goals continued.</p> <p style="padding-left: 40px;">b. May show no progress and change of approach.</p> <p style="padding-left: 40px;">c. May show accomplishment of short term goal and new goal and approach.</p> <p>7. Care plan identifies the patient/resident problem, where you are with a resident, where you are going (goals), and how you are going to get there (plan/approach)...."</p> | | | | | | |

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| F0282 SS=D | <p>3.1-35(d)(2)(B)</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 observation, record review and interview, the facility failed to ensure a resident with orders for comfort measures only had as needed pain medication ordered for 1 of 1 resident reviewed with comfort measures only (Resident #101) and failed to ensure a resident had restorative nursing services as indicated in the health care plan for 1 of 3 residents reviewed for restorative nursing care (Resident #19) in a Stage 2 Sample of 34.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #101 was reviewed on 7/13/11 at 1:00 p.m.</p> <p>Resident #101's current diagnoses included, but were not limited to, acute encephalopathy, subdural hematoma and dysphagia.</p> <p>During observation on 7/14/11 11:00 a.m., Resident #101 was lying in a low bed in her room. The resident</p> | F0282 | <p>F-282</p> <p>Resident #19 was screened by therapy in which Occupational Therapy requested an evaluation. Resident evaluated on 7/29/11 with a plan of care implemented to address contracture management. Resident #101 was seen by medical Director on 7/14/11 in which PRN pain medication was ordered. Pain assessment was completed 7/28/11 no signs or symptoms of pain noted by resident. Care plan was reviewed and revised. Resident having the potential to be affected by the deficient practice: Residents with orders for comfort care only. Residents who have contractures. An audit for residents with contractures was completed by the R.S.M., Med. Records, Nursing Management on 7/22/11. Staff to refer to Occupational Therapy and or restorative nursing for contracture management/range of motion. Residents that receive comfort care orders will have P.R.N. medications as needed for pain and Care Plan in place to reflect current pain management interventions.</p> <p>An in-service for nursing staff was</p> | 08/08/2011 | | | |

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| | <p>was curled into a fetal position with the covers over her head.</p> <p>A recapitulation of physician's orders, dated 6/29/11, indicated Resident #101 had orders for the following pain medications:</p> <p>Tylenol (a pain medication) 500 mg, tablet 1, four times daily routinely Tylenol 325 mg, 2 tablets, every 6 hours as needed for mild to moderate pain Hydrocodone with Acetaminophen (a narcotic pain medication) 5-325 mg, 1 tablet, every 6 hours as needed for moderate to severe pain.</p> <p>A physician's order, dated 6/30/11, indicated the following, comfort care per care plan conference, due to end stage dementia, discontinue oral medications except Depakote 125 milligrams (anti-seizure medication) twice daily, discontinue weekly weights, and discontinue nutrition intervention program.</p> <p>The clinical record as of 6/30/11 lacked any information related to any non-oral medications to be given to the resident on a routine or as needed basis for pain.</p> <p>A health care plan, dated 7/1/11,</p> | | <p>conducted on 7/28/11 in regards to pain management as well as contracture management and range of motion. Residents with orders for comfort measures will be reviewed weekly on Mega Meeting Day to ensure that orders are in place for pain management and that the Care Plan has been updated. Therapy will screen residents quarterly to identify new or continuing need for Therapy or Restorative Services.</p> <p>DON or designee will monitor five residents 3x week for 4wks then, weekly x 4 weeks, every two weeks for four wks then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters to ensure residents with contractures are being followed and care plan reflects orders and that residents with orders for comfort measures have pain medications as needed. Audits will be submitted for inclusion of PI. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.</p> <p>Completion Date: 8/8/11</p> | | |

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| | <p>indicated the family wishes for comfort care measures only , approaches for this problem included the following,</p> <p>A. Assist with maintaining normal routine as much as possible.</p> <p>B. Ensure comfort</p> <p>C. Encourage family involvement in care planning to help with any anxiety provide as much information of the disease process as desired by the family members.</p> <p>D. Address pain issues as needed</p> <p>Clinical record review indicated the resident had no routine and or as needed pain medication ordered.</p> <p>During an interview with the Don (Director of Nursing) on 7/14/11 at 4:10 p.m., she indicated the nursing staff should have asked the physician for pain medication that was not an oral route when he discontinued all oral medications for the resident on 6/30/11.</p> <p>2.) The clinical record for Resident #19 was reviewed on 7/12/11 at 2:30 p.m.</p> | | | | |

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| | <p>Resident #19's current diagnoses included, but were not limited to, osteoarthritis and generalized weakness.</p> <p>During observation on 7/11/11 at 4:00 p.m., Resident #19 was observed in her wheelchair in her room. Her head was tilted to one side.</p> <p>During observation on 7/13/11 at 2:15 p.m., the resident was observed in a wheelchair in her room. The resident's eyes were closed. Her head tilted to one side, to almost her shoulder area.</p> <p>A health care plan, dated 6/11, indicated the resident had a problem listed as, has contractures to neck and is at risk for further contractures related to decreased mobility, diagnosis of osteoarthritis and degenerative joint debility, approaches for this problem included, restorative to do AROM,(active range of motion) exercises, observe for progression of contractures and report to physician, therapy to screen quarterly and as indicated, encourage to and assist with repositioning every 2 hours and as needed and handle resident gently during care and report signs and symptoms of pain to nurse.</p> | | | | | | |

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| | <p>An annual Minimum Data Set Assessment, dated 6/30/11, indicated the resident had impairment on both sides with ROM (range of motion) of the upper extremities (shoulder, elbow, wrist, hand).</p> <p>During an Interview with the DoN on 7/13/11 at 4:00 p.m., she indicated the facility had no record of the nursing staff having provided the resident any restorative nursing services. She indicated the facility had no record of any AROM exercises having been completed. She further indicated she was not sure if the resident could tolerate any of the exercises. She indicated the nursing staff would re-evaluate the resident's contractures and the need for restorative nursing. The DoN indicated she would have the nursing staff and the therapy department assess the resident for worsening contractures and evaluate if any treatment would be beneficial for the resident.</p> <p>3.1-35(g)(2)</p> | | | | |

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| F0309 SS=E | <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff administered sliding scale insulin as ordered by the physician for 3 of 3 residents (Resident #'s 96, 39, and 27) reviewed for administration of sliding scale insulin and failed to ensure effective pain management for a resident receiving an as needed narcotic pain medication in that the resident was receiving the prn medication routinely for 1 of 3 residents (Resident #95) reviewed for pain monitoring in a Stage 2 Sample of 34.</p> <p>Findings include:</p> <p>1.) The clinical record for resident #96 was reviewed on 7/13/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, depression, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>A health care plan problem, dated</p> | F0309 | <p>F-309 1. Resident #96 was seen by Nurse Practitioner on 7/20/11 for Diabetic management in which insulin was adjusted and care plan was reviewed. Resident #39 sliding scale orders reviewed with no changes made. Resident # 27 was admitted to the hospital for unrelated concerns and returned with new sliding scale orders. Care plan updated as needed on 7/24/11. Resident #95 was seen by medical director for review of pain medications with new orders received On 7/23/11. Pain assessment was completed on 7/18/11 and care plan was reviewed. 2. Residents with sliding scale insulin coverage and residents utilizing PRN pain medication may be affected. An audit for residents with sliding scale coverage and PRN pain medications was completed by Nursing Management 7/18/11 to identify those residents with the potential to be affected. Orders reviewed and care plans updated as needed by 8/5/11. 3. Policy for medication administration and pain management was reviewed 7/15/11 with no changes. Nurses will document number of units of insulin on the MAR as indicated by glucometer reading. PRN medications will be initialed as</p> | 08/08/2011 | |

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| | <p>5/24/11, indicated Resident #96 had a diagnosis of diabetes mellitus and was at risk for experiencing episodes of low or elevated blood sugars. Approaches for this problem included, but were not limited to, "Glucometer checks as ordered" and "Administer medication as ordered."</p> <p>A recapitulation of physician's orders, dated 7/3/11, indicated Resident #96 received routine insulin injections three times daily for her diabetes. The orders also indicated Resident #96 was to receive Novolog insulin per sliding scale based on glucose results taken before meals and at bedtime. The sliding scale insulin orders included, but were not limited to, the following:</p> <p>Blood sugar 181-250=give 4 units of Novolog insulin Blood sugar 251-300=give 6 units of Novolog insulin</p> <p>The June and July Medication Administration Records (MAR) lacked documentation of sliding scale insulin having been given based on the glucometer results on the following dates and times:</p> <p>6/2/11 at 6 a.m.-blood sugar 204-no insulin documented as having been</p> | | <p>given on the front of the MAR and effectiveness to medication will be documented per facility policy. An in-service with nursing staff regarding PRN pain medication administration with follow up of effectiveness and Documentation of sliding scale insulin was conducted S.D.C. on 7/28/11. 4. DON or designee will monitor five residents for proper pain medication documentation 3x week for 4wks, weekly x 4 weeks, then every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion of PI. DON or designee will monitor for accurate and complete documentation of sliding scale coverage for five residents 3x week for 4 weeks, the weekly x 4 weekly, then every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.5. Completion Date: 8/8/11</p> | | |

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| | <p>given 6/2/11 at 11 a.m. -blood sugar 188-no insulin documented as having been given</p> <p>given 6/3/11 at 11 a.m. -blood sugar 238-no insulin documented as having been given</p> <p>given 6/10/11 at 4 p.m. -blood sugar 218-no insulin documented as having been given</p> <p>given 6/11/11 at 4 p.m.-blood sugar 205-no insulin documented as having been given</p> <p>given 6/11/11 at 8 p.m.-blood sugar 217-the MAR indicated a "zero" for no insulin having been given</p> <p>given 6/20/11 at 4 p.m.-blood sugar 197-no insulin documented as having been given</p> <p>given 6/21/11 at 4 p.m.-blood sugar 199-no insulin documented as having been given</p> <p>given 6/22/11 at 8 p.m.-blood sugar 197-no insulin documented as having been given</p> <p>given 6/25/11 at 4 p.m.-blood sugar 274-no insulin documented as having been given</p> <p>given 6/26/11 at 4 p.m.-blood sugar 190-no insulin documented as having been given</p> <p>given 6/29/11 at 6 a.m.-blood sugar 210-no insulin documented as having been given</p> <p>given 6/30/11 at 11 a.m.-blood sugar 188-no</p> | | | | |

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| | <p>insulin documented as having been given 7/7/11 at 6 a.m.-blood sugar 202-no insulin documented as having been given</p> <p>During an interview with the Director of Nursing (DON) on 7/13/11 at 3:48 p.m., additional information was requested related to the sliding scale insulin not being given as ordered by the physician on the dates noted above.</p> <p>During an interview on 7/14/11 at 8:50 a.m., the DON indicated she had no information to provide related to the inaccurate or missing insulin coverage for the dates noted above.</p> <p>2.) Resident #39's clinical record review was completed on 7/14/11 at 9:42 a.m.</p> <p>The resident had a 5/26/11, quarterly MDS [Minimum Data Set] assessment. The assessment indicated Resident #39 had moderate cognitive impairment related to decision making.</p> <p>The resident's current physician's orders were signed and dated on 6/10/11 by the physician. The resident's diagnoses included, but</p> | | | | |

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| | <p>were not limited to, diabetes mellitus type II and muscle weakness.</p> <p>Resident #39 had a sliding scale insulin coverage order for Humalog 100 units per milliliter to be given subcutaneously for the following blood sugar ranges: 141 - 180 give 1 unit 181 - 220 give 2 units 221 - 260 give 4 units 261 - 300 give 6 units 301 - 340 give 7 units 341 - 380 give 8 units 381 - 420 give 9 units 421 - 460 give 10 units greater than 460 give 12 units.</p> <p>Review of the July, 2011, MAR [Medication Administration Record] indicated Resident #39 had a blood sugar of 146 at 6:00 a.m., on 7/7/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given. The resident had a 6:00 a.m., blood sugar of 159 on 7/9/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given. The resident had a 6:00 a.m., blood sugar of 171 on 7/13/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given.</p> | | | | | | |

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| | <p>During an interview on 7/14/11 at 8:50 a.m., the Director of Nursing indicated she had no information to provide related to the missing sliding scale insulin coverage.</p> <p>3.) The clinical record for Resident #27 was reviewed on 7/12/11 at 9:00 a.m.</p> <p>Resident #27's current diagnoses included, but were not limited to, Schizophrenia, diabetes mellitus, and anxiety.</p> <p>The resident had current physician's orders for the following:</p> <p>Resident #27 had a health care plan, dated 6/11, which indicated the resident had a problem listed as, resident has a diagnosis of diabetes mellitus and blood sugars are unstable. Approaches for this problem included: Monitor blood sugars as ordered, administer medications per order, administer insulin per order and oversee available labs.</p> <p>A. Monitor blood sugars two times daily at 6 a.m. and 4 p.m.</p> <p>B. Inject Lantus insulin 70 units at</p> | | | | |

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| | <p>bedtime.</p> <p>C. Inject Novolog insulin according to blood sugar results use sliding scale as follows</p> <p>200-250 = 4 units 251-300 = 6 units 301-350 = 8 units greater than 350 call the physician.</p> <p>Review of the May, and June 2011 Medication Administration Records indicated on the following dates and times Resident #27 did not have her blood sugar monitored as ordered and or received the incorrect sliding scale insulin dose,</p> <p>MAY</p> <p>May 19 at 6 a.m., no blood sugar result was documented as having been completed</p> <p>May 19, blood sugar was 209 at 4 p.m., no sliding scale insulin was given. The resident should have received 4 units</p> <p>May 29, at 6 a.m., no blood sugar result was documented as having been completed.</p> <p>May 29, blood sugar at 4 p.m., was</p> | | | | |

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| | <p>380. No sliding scale insulin was documented as having been given. The resident's physician should have been called and insulin orders received for a blood sugar result greater than 350.</p> <p>June</p> <p>June 4th, 6 a.m., blood sugar was 235. No sliding scale insulin was given. The resident should have received 4 units.</p> <p>June 6th, 6 a.m., blood sugar was 215. No sliding scale insulin was given. The resident should have received 4 units.</p> <p>June 15, 6 a.m., No blood sugar result was documented.</p> <p>June 29, 6 a.m., blood sugar result was 205. No insulin was documented as given. The resident should have received 4 units.</p> <p>During an interview with the DoN on 7/13/11 at 4:15 p.m., additional information was requested related to the lack of sliding scale insulin coverage having been given, and any blood sugar results that were not documented as having been completed.</p> | | | | | | |

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| | <p>During an interview with the DoN on 7/14/11 at 8:30 a.m., she indicated she could not find any indication the sliding scale insulin had been given on the dates and times noted above. She further indicated she had no information to provide related to the lack of blood sugar monitoring on the dates and times noted above. The DoN indicated she did not know if the physician was notified of the elevated blood sugar of 380 on May 29th at 4 p.m. She indicated the nursing staff should have entered the blood sugar results and the sliding scale insulin that was given on the Medication Administration Record.</p> <p>4.) Resident #95's Clinical Record review was completed on 7/13/11 at 2:12 p.m. The resident's diagnoses included, but were not limited to, L4-5 diskus, intercococcus bacteremia, diabetes, neuropathy, and persistent pain.</p> <p>The resident's current physician's orders were signed and dated by the physician on 7/13/11. The orders included an order for hydrocodone-apap [a narcotic pain medication] 5-325 mg, one tablet orally, every four hours as needed for moderate to severe pain.</p> | | | |

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| | <p>Review of the resident's MAR [Medication Administration Record] for July, 2011 indicated the resident had received hydrocodone-apap 5/325 mg on the following dates:</p> <p>7/3 - one time 7/4 - three times 7/6 - three times 7/7 - one time 7/8 - one time 7/9 - one time 7/11 - four times 7/12 - three times 7/13 - one time 7/14 - two times</p> <p>The back of the MAR indicated the resident received the hydrocodone-apap 5/325 mg for pain and was effective on 7/4/11 at 3:45 p.m. and 8:20 p.m., 7/9/11 at 9:00 a.m., and on 7/14/11 at 9:30 a.m. The MAR indicated the resident received the medication 16 times without indicating the reason for the medication or the effectiveness of the medication.</p> <p>Review of the hydrocodone/apap 5/325 mg Controlled Substance Record for July, 2011, indicated the medication had been signed out on the following dates and times:</p> | | | | |

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| | 7/1 at 12:15 a.m., 5:30 a.m., 10:30 a.m., and 7:00 p.m. 7/2 at 12:30 a.m., 5:00 a.m., 9:00 a.m., and 5:00 p.m. 7/3 at 12:45 a.m., 4:30 a.m., 10:00 a.m., 3:00 p.m., and 8:00 p.m. 7/4 at 12:00 a.m., 4:00 a.m., 3:45 p.m., and 8:20 p.m. 7/5 at 1:30 a.m., 5:30 a.m., 2:45 p.m., 7:15 p.m., and 11:30 p.m. 7/6 at 4:00 a.m., 9:30 a.m., 1:30 p.m., 5:30 p.m., and 9:30 p.m. 7/7 at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. 7/8 at 1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 4:00 p.m., and 9:00 p.m. 7/9 at 5:00 a.m., 9:00 a.m., 5:00 p.m., and 9:00 p.m. 7/10 at 1:00 a.m., 5:00 a.m., 10:30 a.m., 5:00 p.m., 9:30 and p.m. 7/11 at 1:30 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:20 p.m. 7/12 at 2:45 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:15 p.m. 7/13 at 3:05 a.m., 7:45 a.m., 12:30 p.m., 5:00 p.m., and 9:20 p.m. 7/14 at 3:15 a.m. and 9:30 a.m. The Controlled Substance Record indicated the pain medication was signed out for the resident a total of 63 times in July, but was only recorded on the front of the MAR as having been given 20 times. The resident received the medication 43 | | | | | | |

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| | <p>times without documentation of the medication being given on the MAR.</p> <p>During interviews on 7/14/11 at 8:50 a.m., and on 7/15/11 at 12:30 p.m., the Director of Nursing indicated she had no additional information to provide related to the lack of documentation of the need for or the effectiveness of the hydrocodone/apap medication which was signed on the Controlled Substance Record but not recorded on the MAR on the dates and times noted above.</p> <p>5.) The revised 10/4, "Policy for Medication Administration" was provided by the Director of Nursing on 7/14/11 at 2:00 p.m. The policy indicated the initials of the person administering a medication should be placed in the correct box on the MAR after a medication is given. The policy indicated PRN [as needed] medications are charted with initials and the time it is given in the corner of the box on the MAR. It the following situations require a an accompanying note:</p> <ol style="list-style-type: none"> behaviors requiring the use of a PRN psychotropic medication. fever. pain any situation that requires | | | | |

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| F0312 SS=G | <p>monitoring.</p> <p>6.) Review of the current facility policy, dated 3/2007, titled "Pain Management Protocol, provided by the Director of Nursing on 7/15/11 at 12:30 p.m., included, but was not limited to, the following:</p> <p>"Objective</p> <p>To control/manage the pain a resident may be experiencing due to any disease process or an identified cause.</p> <p>Procedure</p> <p>...4. Nursing staff will monitor and document the effectiveness of the pain management program in the resident medical record...."</p> <p>3.1-37(a)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure residents who required the</p> | F0312 | F-312 We respectfully request IDR of this tag.1. Resident #96 was immediately assisted with oral care. A new oral assessment | 08/08/2011 | |

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| | <p>assistance of the staff for personal hygiene needs received that care in accordance with facility policy and plan of care. This affected 2 of 3 residents reviewed for assistance with personal hygiene in a Stage 2 Sample of 34. (Resident # 96 and #18) This resulted in the development of inflamed soft oral tissues for 1 resident (#96) who needed assistance with oral/dental care.</p> <p>Findings:</p> <p>1.) The clinical record for resident #96 was reviewed on 7/13/11 at 10:30 a.m. The clinical record indicated Resident #96 was admitted on 5/24/11.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, depression, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>An admission Minimum Data Assessment, dated 6/2/11, indicated Resident #96 had no problems with memory or recall and was not cognitively impaired. The assessment indicated she had no oral or dental problems and required extensive assistance from one staff member for personal hygiene needs.</p> | | <p>was completed as well as a pain assessment on 7/27/11, in which resident denied pain. Gums were pink and moist with no inflammation noted. Resident was referred to Occupational therapy for oral care. Resident's care plan was updated to reflect oral care on 7/27/11. Resident #18 had her clothing changed and resident had chin hair removed. Residents requiring assistance with ADL's have the potential to be affected. MDS's reviewed by Nursing Management to identify those residents requiring assistance with personal hygiene including oral care, unwanted facial hair and clean clothing by 7/27/11. Care Guide updated as needed.</p> <p>Oral care policy was reviewed with no changes on 7/15/11. The Care Guide for those residents requiring assistance updated as needed to specifically address types and frequency of oral care needed. A inservice for nursing staff was conducted on 7/28/11 in regards to ADL care including oral care, clean clothing and shaving of unwanted facial hair</p> <p>DON or designee will audit via interviews or observation to ensure that proper oral care has been given and that residents are clean, clothing is not stained and they are free of unwanted facial hair for five residents 3x week x 4weeks then, weekly x 4 weeks, every two weeks x four weeks, then monthly x 3 months then</p> | | |

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| | <p>An Oral Assessment Form, dated 5/26/11, indicated Resident #96 had upper dentures and lower natural teeth with two teeth missing. The form indicated the resident's mucous membranes and gums were pale and slightly dry.</p> <p>A health care plan problem, dated 6/13/11, indicated Resident #96 required assistance from the staff for completing all activities of daily living related to weakness, right hemiplegia, CVA.... One of the approaches for this problem was for staff to set up supplies and assist resident with oral care. The approach did not indicate how often oral care was to be given.</p> <p>During an interview on 7/12/2011 at 9:48 a.m., Resident #96 indicated her dentures had only been cleaned once in the last week. She indicated her natural teeth had not been brushed since she was admitted. She indicated she needed the assistance of the staff to set up supplies and assist her with brushing her teeth due to paralysis of one arm/hand.</p> <p>During an observation with CNA #2 (the CNA who provided care to the Resident #96 on the 7-3 shift) on 7/13/11 at 3 p.m., she located a tube</p> | | <p>quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. ProgramThe P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.. Completion Date: 8/8/11</p> | | |

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| | <p>of toothpaste (appeared full or almost full), a box of denture cleaning tablets, a dental cup, and two dry toothbrushes in the resident's drawer.</p> <p>During an interview at this time, CNA #2 indicated she had not assisted Resident #96 with any type of dental care during her shift.</p> <p>The "Daily care" monthly flow reports for May, June, and July, 2011 were blank for the category of "dentures cleaned" for all three months.</p> <p>A dental exam report, dated 7/11/11, indicated the resident wore upper dentures, but her lower teeth were natural. The report indicated her oral hygiene was poor and her soft tissues were red and inflamed. The report indicated the dentist spoke about taking the resident's dentures out at night so the soft tissue could "breathe". The report indicated "Clean denture for pt [patient]."</p> <p>A nursing note entry, dated 7/11/11 at 2:00 p.m., indicated the dentist had visited and cleaned the resident's teeth. The note lacked any information related to the need to take the resident's teeth out at night.</p> <p>During an interview with the Director</p> | | | | |

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| | <p>of Nursing and Resident #96 on 7/13/11 at 3:55 p.m., Resident #96 indicated she had only been given oral/dental care once since admission which was done once by the dentist when she was seen by him earlier in the week.</p> <p>2.) The clinical record for Resident #18 was reviewed on 7/13/11 at 2:50 p.m.</p> <p>Diagnosis for Resident #18 included, but were not limited to, dementia with behavior, muscle weakness, diabetes mellitus type 2, obesity, osteoarthritis, chronic airway obstruction, depressive disorder, mononeuritis, hyperlipidemia, anxiety, pain, constipation, keratoderma, esophageal reflux, hypertension, anemia, senile delusion, tear film insufficiency, Alzheimer's disease, debility, psychosis, neuropathy, edema, and circulatory disease.</p> <p>On 7/12/11 at 9:45 a.m., Resident #18 was observed with facial hair on her chin and a large soiled area on the front of her shirt.</p> <p>A health care plan problem, dated 7/23/08, indicated Resident #18 required assistance from the staff for completing all ADL's (Activities of</p> | | | | | | |

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| | <p>Daily Living) related to dementia, decline in cognition, decline in mobility, cerebrovascular accident (CVA). One of the approaches for this problem was for the staff to dress the resident in clothes that are clean and in good repair.</p> <p>A Quarterly Review Minimum Data Set assessment (MDS), dated 4/14/11, indicated Resident #18 had a Brief Interview for Mental Status (BIMS) score of 3 (which indicates the resident has severe cognitive impairment). The assessment indicated she required extensive assistance from one staff member for dressing and personal hygiene needs.</p> <p>Activities of Daily Living (ADL) documentation indicated Resident #18 had been shaved once during July, twice in June, and 3 times in May.</p> <p>3.) Review of the current facility policy, titled "Oral Hygiene: Cleaning Dentures," provided by the DoN on 7/14/11, at 2:00 p.m., included, but was not limited to, the following:</p> <p>"Policy</p> <p>The purpose of the procedure is:</p> | | | | |

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| | <p>To cleanse and freshen the resident's mouth.</p> <p>To clean the resident's teeth.</p> <p>To lessen the potential of infections in the mouth....</p> <p>1. Provide dental care before breakfast and at bedtime. Instruct the resident to rinse his/her mouth out after each meal....</p> <p>...9. As you provide denture care, examine the resident's mouth and gums for any paleness of the gums, mouth sores, any bleeding and areas of discoloration....</p> <p>...Reporting Procedures:</p> <p>The nursing assistant must report the following information to the staff/charge nurse:</p> <p>1. That denture care has been given....</p> <p>...Plan of Care:</p> <p>The resident's plan of care must address:</p> <p>1. The type of dental care to be provided.</p> | | | | |

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| | <p>2. The frequency of the care.</p> <p>3. Special devices necessary, if any.</p> <p>4. Who is responsible for providing the care....</p> <p>4.) Review of the current facility policy, titled "Oral Hygiene: Conscious Resident," provided by the DoN on 7/14/11, at 2:00 p.m., included, but was not limited to, the following:</p> <p>"Policy</p> <p>The purpose of the policy is to:</p> <p>Cleanse and freshen the resident's mouth. Clean the resident's teeth. Decrease the risk of infections within the mouth....</p> <p>...Key Procedural Points</p> <p>1. Provide dental care before breakfast and at bedtime. Instruct the resident to rinse his/her mouth after each meal....</p> <p>...Reporting Procedures:</p> <p>The nursing assistant must report the</p> | | | | |

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| | <p>following information to the staff/charge nurse:</p> <ol style="list-style-type: none"> 1. That special mouth care has been given.... <p>...Plan of Care:</p> <p>The resident's plan of care must address:</p> <ol style="list-style-type: none"> 1. The type of dental care to be provided. 2. The frequency of the care. 3. Special devices necessary, if any. 4. Who is responsible for providing the care? 5. Other information as necessary or appropriate...." <p>3.1-38(a)(3)(C) 3.1-38(a)(3)(D)</p> | | | | |

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| F0315 SS=D | <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident who was incontinent of urine at times received incontinence care to maintain adequate hygiene for 1 of 3 residents reviewed for incontinence care in a Stage 2 Sample of 34. (Resident #27)</p> <p>Findings include:</p> <p>The clinical record for Resident #27 was reviewed on 7/12/11 at 9:00 a.m.</p> <p>Resident #27's current diagnoses included, but were not limited to, Schizophrenia and anxiety.</p> <p>During observation on 7/11/11 at 11:30 a.m., Resident #27 was sitting on her bed in her room. A strong odor</p> | F0315 | <p>F-315 1. Resident #27 was immediately showered and assisted with care. Resident discharged to hospital 7/15/11. She was readmitted on 7/27/11 and orders were received for Occupational Therapy to evaluate and treat as indicated. Occupational Therapy to address urinary incontinence program. Care plan updated for resident to be showered daily. 2. Incontinent residents may be affected. An audit for incontinent residents was completed by Nursing Management on 8/2/11. Nursing staff will assist with providing peri care for incontinent residents as needed. Staff to refer to restorative nursing and / or Occupational Therapy for toileting programs as indicated. 3. An in-service for nursing staff was conducted by the S.D.C. on 7/28/11 in regards to ADL care including peri care and toileting. Occupational Therapy to screen</p> | 08/08/2011 | |

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| | <p>was immediately noted. The odor was body odor and/or urine odor.</p> <p>During observation on 7/11/11 at 2:30 p.m., Resident #27 was in her room in her bed. A slight urine odor was noted in the room.</p> <p>During observation on 7/12/11 at 9:00 a.m., a strong urine odor and body odor was noted in the resident's room.</p> <p>Review of the shower record for May, June, and July 2011 indicated the resident had received showers twice weekly for all 3 months. The record indicated the resident received a sponge bath daily on the days she had not received a shower.</p> <p>The bladder flow sheet for the month of July indicated on July 10 the resident was continent of bladder. On July 11 day shift, the resident was incontinent of bladder 1 time on the day shift. On July 12, the resident was incontinent of bladder 1 time on the day shift.</p> <p>A Health care plan, dated 5/1/11, indicated the resident had a problem listed as, requires assist in completing ADL's due to weakness and episodes of incontinence. The goal for the</p> | | <p>residents quarterly. Restorative nurse to assess toileting programs quarterly.4.DON or designee will monitor via observation to ensure that proper peri care has been provided for five residents 3x weekly for 4weeks then weekly for 4 weeks, then every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. 5. Completion Date: 8/8/11</p> | | |

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| | <p>health care plan was the resident will assist with dressing self daily thru next review. Approaches for this problem included: set up clothing and assist resident with dressing and undressing, set up personal hygiene products and assist with oral care, hair care, nail care, a.m. and p.m. care, perineal care, and assist with showers 2 times a week with partials on non-shower days, observe for changes in level of participation with ADL's (activities of daily living) and refer to therapy screening if needed.</p> <p>During an interview on 7/13/11 at 1:20 p.m., with LPN #4, the nurse assigned to care for Resident #27, she indicated the resident was able to take herself to the bathroom and she completed her own peri care. She further indicated the resident did not always "do a good job" with her peri care. LPN #4 indicated she had "occasionally" noted a urine odor in the resident's room. She indicated the CNAs who were assigned to the resident would have to monitor the resident's bathing and toileting needs more closely.</p> <p>The monthly flow record, used to monitor bladder continence, for June 2011, for the reference period of the MDS June 2 thru June 8th indicated</p> | | | | |

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| F0318 SS=D | <p>the resident was incontinent of bladder 10 times on the following dates and times,</p> <p>A. June 2, 1 time on night shift B. June 3, 1 time on day shift C. June 4, 3 times on evening shift and 2 times on night shift D. June 5, 1 time on night shift E. June 6, 1 time on day shift F. June 8, 1 time on evening shift</p> <p>3.1-41(a)(2)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure a resident who had contractures was provided treatment and assessed for possible changes in treatment to prevent further progression of contractures for 1 of 3</p> | F0318 | F-318 1. Resident #19 was screened by therapy in which Occupational Therapy requested an evaluation. Resident evaluated on 7/29/11 with a plan of care implemented to address contracture management. 2. Residents with contractures may | 08/08/2011 | |

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| | <p>residents reviewed with contractures in a Stage 2 sample of 34. (Resident #19)</p> <p>Findings include:</p> <p>The clinical record for Resident #19 was reviewed on 7/12/11 at 2:30 p.m.</p> <p>Resident #19's current diagnoses included, but were not limited to, osteoarthritis and generalized weakness.</p> <p>During observation on 7/11/11 at 4:00 p.m., Resident #19 was observed in her wheelchair in her room. Her head was tilted to one side.</p> <p>During observation on 7/13/11 at 2:15 p.m., the resident was observed in wheelchair in her room. The resident's eyes were closed. Her head tilted to one side, to almost her shoulder area.</p> <p>A health care plan, dated 6/11, indicated the resident had a problem listed as, has contractures to neck and is at risk for further contractures related to decreased mobility, diagnosis of osteoarthritis and degenerative joint debility, approaches for this problem included, restorative to do AROM,(active range of motion)</p> | | <p>be affected. An audit for residents with contractures was completed by Restorative Services Manager, Medical Records and Nursing Management by 7/22/11. Staff to refer to Occupational Therapy and or restorative nursing for contracture management/range of motion. 3. An in-service for nursing staff was conducted by the S.D.C. on 7/28/11 in regards to contracture management/range of motion. Therapy to screen residents quarterly. Restorative nursing will assess residents on range of motion programs quarterly for effectiveness of plan. 4. DON or designee will monitor five residents to ensure ordered treatments for residents with contractures are being followed and care plan reflects order, 3x weekly for 4weeks, then weekly x 4 weeks, every two weeks for four weeks then monthly for 3 months then quarterly until 100% compliance is attained and maintained for 2 quarters Audits will be submitted for inclusion of PI.The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.5. Completion Date: 8/8/11</p> | | |

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| | <p>exercises, observe for progression of contractures and report to physician, therapy to screen quarterly and as indicated, encourage to and assist with repositioning every 2 hours and as needed and handle resident gently during care and report signs and symptoms of pain to nurse.</p> <p>An annual Minimum Data Set Assessment, dated 6/30/11, indicated the resident had impairment on both sides with ROM (range of motion) of the upper extremities (shoulder, elbow, wrist, hand).</p> <p>During an Interview with the DoN on 7/13/11 at 4:00 p.m., she indicated the facility had no record of the nursing staff having provided the resident any restorative nursing services. She indicated the facility had no record of any AROM exercises having been completed. She further indicated she was not sure if the resident could tolerate any of the exercises. She indicated the nursing staff would re-evaluate the resident's contractures and the need for restorative nursing. The DoN indicated she would have the nursing staff and the therapy department assess the resident for worsening contractures and evaluate if any treatment would be beneficial for the</p> | | | | | | |

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| F0329 SS=D | <p>resident.</p> <p>3.1-42(a)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents with orders for blood pressure medications, hypnotics, and/or narcotic pain medication were monitored for the administration and/or effectiveness of the medication for 3 of 10 residents reviewed for unnecessary medication use in a Stage 2 Sample of 34. (Resident #'s 96, 81, and 95)</p> | F0329 | F-329 1. Resident #81 had pain assessment updated 7/14/11 with no complaints noted. Care plan revised to include type and frequency of pain. Resident seen by Nurse Practitioner on 7/20/11. Staff on duty educated immediately regarding procedure for documenting narcotics and follow-up monitoring. Resident #96. Staff on duty immediately educated by Nursing Management. Daily follow-up education was provided by | 08/08/2011 | |

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| | <p>Findings include:</p> <p>1.) The clinical record for Resident #81 was reviewed on 7/13/11 at 9:30 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, congestive heart failure and hypertension.</p> <p>A pain assessment, dated 6/25/11 and updated on 7/14/11, indicated Resident #81 was at risk for pain and had experienced pain in the past. The assessment lacked any information related to the type of pain experienced by the resident currently or in the past.</p> <p>During an interview on 7/11/11 at 3:09 p.m., Resident #81 indicated she had a history of chronic back and leg pain. She indicated she was receiving routine pain medications, but they were not "holding her pain." She was observed during the interview to be making a rocking motion back and forth in her chair. She indicated this movement sometimes helped to relieve her back pain. She indicated it was not yet time for any more pain medication.</p> <p>An "Interim Care Plan" for Resident #81, dated 6/25/11, indicated she</p> | | <p>Nursing Management to Nurses on duty. Resident #95 was seen by Medical Director for pain management with new orders received, pain assessment completed on 7/18/11 and care plan revised. Staff on duty educated immediately regarding procedure for documenting narcotics and follow-up monitoring.2. Residents receiving PRN medications, narcotics and residents receiving medications with hold orders have the potential to be affected. An audit of resident orders, the MARS, and the Narcotic sign out sheet was completed by 7/18/11 to determine any other resident affected and appropriate action taken as needed. 3. Policy for medication administration and pain management was reviewed with no changes. Prior to administering PRN pain medication nurses will initiate the pain flow sheet. PRN medications will be initialed on the MAR and effectiveness of medication will be documented. An in-service with nursing staff regarding proper monitoring of medication, including monitoring of prn medications and monitoring drugs with hold orders was conducted by the SDC on 7/28/11. 4. DON or designee will audit 5 resident MARs, Pain flow sheets and Narcotic sign out sheets to ensure proper documentation is in place 3x weekly for 4weeks, then weekly x four weeks, then</p> | | |

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| | <p>"has pain". The care plan lacked any information related to the type of pain and/or frequency of the pain. The care plan listed one intervention for the pain which was "Fentanyl patch (a narcotic pain patch) every 3 days." The care plan lacked any information to the resident having an order for an "as needed" pain medication.</p> <p>Physician's orders, dated 7/3/11, indicated Resident #81 had an order for a Fentanyl patch 25 mcg/hr (micrograms per hour) to be applied and changed every 3 days. The orders also indicated the resident could have Hydrocodone with acetaminophen (Norco-a narcotic pain medication) 5/325 mg (milligrams) one tablet two times a day as needed for moderate to severe pain and Zolpidiem Tartrate (Ambien-a hypnotic) 5 mgs at bedtime as needed for insomnia.</p> <p>The "narcotic sign out sheets" for Resident #81 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>7/2/11 at 8 a.m., and 7/8/11 at 8:30 a.m,-the narcotic sign out sheets did</p> | | <p>every two weeks for four weeks, then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.5. Date of compliance is 8/8/11</p> | | |

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| | <p>not indicate what type of pain the medication was given for or if the medication relieved the resident's pain.</p> <p>The Medication Administration Records for Resident #81, lacked any information related to the Norco medication having been given on the two dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record.</p> <p>The "hypnotic sign out sheets" for Resident #81 indicated the Ambien medication was signed out for the resident at bedtime on July 1, 2, 3, 4, 7, and 8, 2011. The Ambien medication was only recorded on the MAR as having been given on 7/1, 7/4, and 7/7/11. No information was recorded on the MAR for 7/2, 7/3, and 7/8/11. The nursing notes lacked any information related to the Ambien medication having been given on those three dates or if the medication was effective.</p> <p>During an interview with the Administrator and Director of Nursing (DON) on 7/14/11 at 2:00 p.m., additional information was requested</p> | | | | |

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| | <p>related to the lack of documentation of administration and monitoring for effectiveness on the dates and times noted above.</p> <p>The facility failed to provide any additional information as of exit on 7/15/11.</p> <p>2.) The clinical record for Resident #96 was reviewed on 7/13/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, hypertension, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>A health care plan problem, dated 5/24/11, indicated Resident #96 had a diagnosis of hypertension. Approaches for this problem included, but were not limited to, "Monitor BP (blood pressure) daily and more often as needed" and "Administer medication as ordered."</p> <p>A recapitulation of physician's orders, dated 7/3/11, indicated Resident #96 had an order for Clonidine (an antihypertensive medication) 0.1 mg (milligram) one tablet three times daily due to hypertension. The order indicated the medication was to be</p> | | | | |

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| | <p>given at 8 a.m., 2 p.m., and 8 p.m. The order indicated the medication was to be held for a systolic blood pressure below 110. The original date of this order was 6/20/11.</p> <p>The Medication Administration Record from 6/20/11 through 7/12/11 lacked any recorded blood pressure reading for the 2 p.m. dose except for 6/23/11 and 6/27/11. This indicated the resident's blood pressure was not monitored at 2 p.m. on 20 occasions during that time period to see if the medication should be withheld.</p> <p>During an interview with the Director of Nursing (DON) on 7/13/11 at 3:45 p.m., additional information was requested related to the lack of blood pressure monitoring as noted above.</p> <p>During an interview on 7/14/11 at 8:50 a.m., the DON indicated she did not have any additional information to provide related to the lack of blood pressure monitoring for 2.p.m.</p> <p>3.) Resident #95's Clinical Record review was completed on 7/13/11 at 2:12 p.m. The resident's diagnoses included, but were not limited to, L4-5 diskus, intercococcus bacteremia, diabetes, neuropathy, and persistent pain.</p> | | | | |

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| | <p>The resident's current physician's orders were signed and dated by the physician on 7/13/11. The orders included an order for hydrocodone-apap [a narcotic pain medication] 5-325 mg, one tablet orally, every four hours as needed for moderate to severe pain. The resident also had an order for zolpidem tartrate [a sleeping pill] 5 mg one tablet orally at bedtime as needed for insomnia.</p> <p>Review of the resident's MAR [Medication Administration Record] for July, 2011 indicated the resident had received hydrocodone-apap 5/325 mg on the following dates: 7/3 - one time 7/4 - three times 7/6 - three times 7/7 - one time 7/8 - one time 7/9 - one time 7/11 - four times 7/12 - three times 7/13 - one time 7/14 - two times</p> <p>The back of the MAR indicated the resident received the hydrocodone-apap 5/325 mg for pain and was effective on 7/4/11 at 3:45 p.m. and 8:20 p.m.; 7/9/11 at 9:00</p> | | | | |

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| | <p>a.m., and on 7/14/11 at 9:30 a.m. The MAR indicated the resident received the medication 16 times without indicating the reason for the medication or the effectiveness of the medication.</p> <p>Review of the hydrocodone/apap 5/325 mg Controlled Substance Record for July, 2011, indicated the medication had been signed out on the following dates and times:</p> <p>7/1 at 12:15 a.m., 5:30 a.m., 10:30 a.m., and 7:00 p.m. 7/2 at 12:30 a.m., 5:00 a.m., 9:00 a.m., and 5:00 p.m. 7/3 at 12:45 a.m., 4:30 a.m., 10:00 a.m., 3:00 p.m., and 8:00 p.m. 7/4 at 12:00 a.m., 4:00 a.m., 3:45 p.m., and 8:20 p.m. 7/5 at 1:30 a.m., 5:30 a.m., 2:45 p.m., 7:15 p.m., and 11:30 p.m. 7/6 at 4:00 a.m., 9:30 a.m., 1:30 p.m., 5:30 p.m., and 9:30 p.m. 7/7 at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. 7/8 at 1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 4:00 p.m., and 9:00 p.m. 7/9 at 5:00 a.m., 9:00 a.m., 5:00 p.m., and 9:00 p.m. 7/10 at 1:00 a.m., 5:00 a.m., 10:30 a.m., 5:00 p.m., 9:30 and p.m. 7/11 at 1:30 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:20 p.m.</p> | | | | |

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| | <p>7/12 at 2:45 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:15 p.m. 7/13 at 3:05 a.m., 7:45 a.m., 12:30 p.m., 5:00 p.m., and 9:20 p.m. 7/14 at 3:15 a.m. and 9:30 a.m.</p> <p>The Controlled Substance Record indicated the pain medication was signed out for the resident a total of 63 times in July, but was only recorded on the front of the MAR as having been given 20 times. The resident received the medication 43 times without documentation of the medication being given on the MAR.</p> <p>Review of the July, 2011, MAR for zolpidem tartrate 5 mg as needed at bedtime indicated the resident received the medication on 7/3, 7/4, and 7/8. The back of the MAR was blank. The clinical record lacked any indication of the need and the effectiveness of the medication.</p> <p>Review of the July, 2011, Controlled Substance Record for the zolpidem tartrate 5 mg indicated the medication was signed out for the resident on 7/1, 7/3, 7/4, 7/5, 7/6, 7/8, 7/9, 7/10, 7/11, 7/12, and 7/13. This indicated the medication was signed out on 8 occasions that were not documented as having been given on the MAR.</p> | | | | |

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| | <p>During interviews on 7/14/11 at 8:50 a.m. and on 7/15/11 at 12:30 p.m., the Director of Nursing indicated she had no additional information to provide related to the hydrocodone/apap and zolpidem being signed out and not documented on the MAR.</p> <p>The revised 10/4, "Policy for Medication Administration" was provided by the Director of Nursing on 7/14/11 at 2:00 p.m. The policy indicated the initials of the person administering a medication should be placed in the correct box on the MAR after a medication is given. The policy indicated PRN [as needed] medications are charted with initials and the time it is given in the corner of the box on the MAR. It the following situations require a an accompanying note:</p> <ol style="list-style-type: none"> behaviors requiring the use of a PRN psychotropic medication. fever. pain any situation that requires monitoring. <p>The policy indicated medications that requires blood pressure parameters is to be charted on the MAR.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> | | | | |

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| F0371 SS=E | <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure all items on room trays were covered while being transported from the food cart to the resident rooms for 1 of 2 food carts observed. This had the potential to affect residents who had meal trays delivered to their rooms.</p> <p>Findings include:</p> <p>During observation on Hickory Hall on 7/12/11 at 12:40 p.m., the food cart was observed being transferred from the kitchen to the hall across from the nurses' station. Two CNAs (CNA #15 and CNA #16) were observed passing trays to the residents who eat in their rooms. The CNAs removed the food trays from the cart and transported the trays down the halls to the residents' rooms. The trays had food that was not covered. The dessert, salads and drinks were not covered.</p> | F0371 | <p>F-371</p> <p>All food items were immediately covered. Nursing staff was instructed to take the food cart to the resident room and then remove individual resident trays for delivery.</p> <p>Residents receiving room trays have the potential to be affected. Food items prepared in the kitchen are now covered prior to being transported in the food cart. Nursing staff takes the food cart to the resident room and then removes individual resident trays for delivery.</p> <p>Dietary staff was inserviced on 7/12/11 and 7/13/11 by the Dietary Manager related to covering food items prepared in the kitchen for delivery elsewhere in the building. Nursing staff was instructed immediately by Nursing Management and during an in-serviced conducted by the S.D.C. on 7/28/11.</p> <p>The Dietary Manager or Designee will monitor delivery carts for each meal 3x weekly x 4 weeks, then 1x weekly x 4 weeks then, every 2 weeks x 4 weeks, then monthly</p> | 08/08/2011 | |

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| | <p>During an interview with CNA #15 on 7/12/11 at 12:50 p.m., he indicated this is the way they (CNAs) pass trays everyday. He indicated there is always some food items that were not covered on the trays.</p> <p>The Dietary Manager was summoned and during an interview on 7/12/11 at 1:00 p.m., she indicated there were some food items placed on the trays that were not covered. She indicated the CNAs were to take the cart to the resident's room and then carry the tray into the room.</p> <p>During an interview with CNA #16 on 7/12/11 at 12:55 p.m., she indicated she did not know she was supposed to take the cart to the resident's room. She indicated she always carried the trays from the cart at the nurses station down the halls to the resident's room.</p> <p>3.1-21(i)(3)</p> | | <p>x 3 months then, quarterly until 100% compliance is attained and maintained x 2 quarters. Audits will be submitted for inclusion in the P.I.Program.The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | | |

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| F0428 SS=D | <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the pharmacist noted and reported irregularities in regards to the administration of narcotics and hypnotics for 2 of 5 residents reviewed with physician's orders for narcotics and/or and hypnotics in a Stage 2 Sample of 34. (Resident #'s 81, and 95)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #81 was reviewed on 7/13/11 at 9:30 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, congestive heart failure and hypertension.</p> <p>Physician's orders, dated 7/3/11, indicated Resident #81 had an order for Hydrocodone with acetaminophen (Norco-a narcotic pain medication) 5/325 mg (milligrams) one tablet, two times a day as needed for moderate</p> | F0428 | <p>F-428</p> <p>Resident #81 had pain assessment conducted on 7/14/11 with no complaints noted. Care plan was revised to reflect on history and location of pain. Resident was seen by Nurse Practitioner on 7/20/11 regarding insomnia in which Ambien was discontinued. Consultant Pharmacist was notified of failure to note discrepancy between MAR and narcotic sign out sheet. Resident #95 was seen by Medical Director for pain management, with new orders received. Pain assessment completed on 7/18/11 and care plan was revised. Consultant Pharmacist was notified of failure to note discrepancy between MAR and narcotic sign out sheet on 7/18/11. Residents receiving schedule II, III, IV, or V medications have the potential to be affected. An audit was conducted by the Licensed pharmacist on 7/3/11 and 7/4/11 and the D.O.N. and Medical Director notified of any discrepancies between the MAR and Narcotic sign out sheet. Prior to administering PRN pain</p> | 08/08/2011 | |

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| | <p>to severe pain and Zolpidiem Tartrate (Ambien-a hypnotic) 5 mgs at bedtime as needed for insomnia.</p> <p>The "narcotic sign out sheets" for Resident #81 indicated the Norco pain medication was signed out as having been given on 7/2/11 at 8 a.m.</p> <p>The Medication Administration Records for Resident #81, lacked any information related to the Norco medication having been given at 8 a.m., on 7/2/11.</p> <p>The "hypnotic sign out sheets" for Resident #81 indicated the Ambien medication was signed out for the resident at bedtime on July 2 and 3, 2011. The MAR lacked any information related to the medication having been given at bedtime on those dates.</p> <p>A pharmacist "Consultation Report" indicated the pharmacist reviewed Resident #81's clinical record on 7/6/11. The report lacked any information related to the discrepancies between the MAR and the hypnotic and narcotic sign out sheets.</p> <p>During an interview with the Administrator and Director of Nursing</p> | | <p>medication nurses will initiate the pain flow sheet. PRN medications will be initialed on the MAR and effectiveness of medication will be documented.</p> <p>An in-service was conducted by the Staff Development Coordinator on 7/28/11 regarding PRN pain medication and proper documentation of schedule II, III, IV, or V drugs. Policy for medication administration was reviewed 7/18/11 with no changes. A telephone conference occurred on 7/28/11 in which PRN pharmacy is to have ensure pharmacist consultants report any irregularities of scheduled drug medication administration in comparison to narcotic sign off sheet.</p> <p>DON or designee will monitor pharmacy recommendations for irregularities of scheduled drug medication administration in comparison to narcotic sign off sheet for five residents 3x weekly for 4weeks, then weekly for 4 weeks then, every two weeks for four weeks then monthly for 3 months then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | | | | |

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| | <p>(DON) on 7/14/11 at 2:00 p.m., additional information was requested related to the lack of pharmacy recommendations regarding the irregularities between the MAR and narcotic and hypnotic sign out sheet for Resident #81.</p> <p>The facility failed to provide any additional information as of exit on 7/15/11.</p> <p>2. Resident #95's Clinical Record review was completed on 7/13/11 at 2:12 p.m. The resident's diagnoses included, but were not limited to, L4-5 diskus, intercococcus bacteremia, diabetes, neuropathy, and persistent pain.</p> <p>The resident's current physician's orders were signed and dated by the physician on 7/13/11. The orders included an order for hydrocodone-apap [a narcotic pain medication] 5-325 mg, one tablet orally, every four hours as needed for moderate to severe pain. The resident also had an order for zolpidem tartrate [a sleeping pill] 5 mg one tablet orally at bedtime as needed for insomnia.</p> <p>Review of the resident's MAR [Medication Administration Record] for</p> | | | | |

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| | <p>July, 2011 indicated the resident had received hydrocodone-apap 5/325 mg on the following dates: 7/3 - one time 7/4 - three times 7/6 - three times The back of the MAR indicated the resident received the hydrocodone-apap 5/325 mg for pain and was effective on 7/4/11 at 3:45 p.m. and 8:20 p.m.</p> <p>Review of the hydrocodone/apap 5/325 mg Controlled Substance Record for July, 2011, indicated the medication had been signed out on the following dates and times: 7/1 at 12:15 a.m., 5:30 a.m., 10:30 a.m., and 7:00 p.m. 7/2 at 12:30 a.m., 5:00 a.m., 9:00 a.m., and 5:00 p.m. 7/3 at 12:45 a.m., 4:30 a.m., 10:00 a.m., 3:00 p.m., and 8:00 p.m. 7/4 at 12:00 a.m., 4:00 a.m., 3:45 p.m., and 8:20 p.m. 7/5 at 1:30 a.m., 5:30 a.m., 2:45 p.m., 7:15 p.m., and 11:30 p.m. 7/6 at 4:00 a.m., 9:30 a.m., 1:30 p.m., 5:30 p.m., and 9:30 p.m.</p> <p>The July,2011, MAR did not have an indication of the hydrocodone/apap being given on 7/1, 7/2, and 7/5 and did not have all the doses documented for 7/3, 7/4, and 7/6.</p> | | | | |

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| | <p>Review of the July, 2011, MAR for zolpidem tartrate 5 mg as needed at bedtime indicated the resident received the medication on 7/3, 7/4. The back of MAR was blank.</p> <p>Review of the July, 2011, Controlled Substance Record for the zolpidem tartrate 5 mg indicated the resident received the medication on 7/1, 7/3, 7/4, and 7/5. This indicated the resident received the medication two times that were not documented on the MAR or in the clinical record.</p> <p>Review of the physician's orders indicated the Registered Pharmacist had reviewed Resident #95's clinical record and medication regime on 7/6/11, and had no recommendations related to the hydrocodone/apap and zolpidem tartrate.</p> <p>During interviews on 7/14/11 at 8:50 a.m., and on 7/15/11 at 12:30 p.m., the Director of Nursing indicated she had no additional information to provide related to the hydrocodone/apap and zolpidem being signed out and not documented on the MAR.</p> <p>3.1-25(e)(3)</p> | | | | |

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| F0456 SS=D | <p>3.1-25(i)</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure the drain to 1 of 1 dish machine was free of leaks for 1 of 1 observation.</p> <p>Findings include:</p> <p>The dish machine was observed on 7/14/11 at 10:25 a.m. The drain to the left of the dish machine was leaking on the floor. There was a white discoloration on the floor where the water was dripping.</p> <p>During an interview with the Dietary Manager at the time of the observation, she indicated she had not seen the leak before.</p> <p>3.1-19(bb)</p> | F0456 | <p>F-456</p> <p>The leak under the sink has been repaired. Residents receiving meals prepared in the facility kitchen have the potential to be affected. Leak has been repaired. The Maintenance Director has added inspection of the leak under the dishwasher to the weekly maintenance schedule. The Dietary Manager or Designee will inspect daily for recurring leaks and report to the Maintenance Director and Executive Director. The Administrator or designee will monitor the sink for leaks 3x weekly for 4 weeks, then 1x weekly for 4 weeks then, every 2 weeks for 4 weeks, then monthly x 3 months then, quarterly until 100% compliance is attained and maintained x 2 quarters. Audits will be submitted for inclusion in the P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed. Completion Date: 8/8/11</p> | 08/08/2011 | |

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| F0520 SS=G | <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Quality Assessment and Assurance Committee identified deficient practices and developed plans of action related to the oral hygiene needs for 1 resident resulting in red and inflamed soft gum tissues (Resident # 96); failed to identify discrepancies in documentation of administration of narcotic and hypnotic medications (Residents #81 and # 95); failed to identify the lack of or incorrect dosage of sliding scale</p> | F0520 | F520We Respectfully request IDR of this tag.1 Appropriate Q.A. Plans were developed 8/5/11 for monitoringthe daily provision of oral care, documentation of administration of narcotic and hypnotic medications, incorrect dosage documentation of sliding scale insulin, identifying the need for incontinence care, developing health care plans for pain management. 2. The Director of Nursing and the Executive Director met 7/22/11 with each Department Head and reviewed current reporting practices to ensure that he or she is aware of concerns and that they are | 08/08/2011 | |

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| | <p>insulin (Residents # 96, #39, # 27); failed to identify the need for incontinence care (Resident # 27) and failed to identify the need to develop health care plans for pain management and oral care for (Residents #81 and #96). These practices actually affected 5 residents in the Stage 2 sample of 34 with the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>1.) During an interview on 7/12/2011 at 9:48 a.m., Resident #96 indicated her dentures had only been cleaned once in the last week. She indicated her natural teeth had not been brushed since she was admitted. She indicated she needed the assistance of the staff to set up supplies and assist her with brushing her teeth due to paralysis of one arm/hand.</p> <p>The clinical record for resident #96 was reviewed on 7/13/11 at 10:30 a.m. The clinical record indicated Resident #96 was admitted on 5/24/11. The resident had diagnosis of cerebral vascular accident (CVA-) with right sided paralysis..</p> <p>An Oral Assessment Form, dated</p> | | <p>presented timely to the Q.A. Committee</p> <p>3.The facility Q.A. Program has been reviewed. No changes are indicated at this time. Review of Q.A. concerns will be added to the daily stand-up meeting for immediate inclusion in the Q.A. Program.</p> <p>4.The Executive Director or designee will monitor and report to the Q.A. Committee on a monthly basis the progress of individual action plans and that appropriate follow-up is in progress. The QA Committee will review results of action plans after 12 months to determine further action as necessary.</p> <p>5.Completion Date: 8/8/11</p> | | |

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| | <p>5/26/11, indicated Resident #96 had upper dentures and lower natural teeth with two teeth missing. The form indicated the resident's mucous membranes and gums were pale and slightly dry.</p> <p>A health care plan problem, dated 6/13/11, indicated Resident #96 required assistance from the staff for completing all activities of daily living related to weakness, right hemiplegia, CVA.... One of the approaches for this problem was for staff to set up supplies and assist resident with oral care. The approach did not indicate how often oral care was to be given.</p> <p>A dental exam report, dated 7/11/11, indicated the resident wore upper dentures, but her lower teeth were natural. The report indicated her oral hygiene was poor and her soft tissues were red and inflamed. The report indicated the dentist spoke with the staff about taking the resident's dentures out at night so the soft tissue could "breathe". The report indicated "Clean denture for pt [patient]."</p> <p>During an observation with CNA #2 (the CNA who provided care to the Resident #96 on the 7-3 shift) on 7/13/11 at 3 p.m., she located a tube of toothpaste (appeared full or almost</p> | | | | | | |

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| | <p>full), a box of denture cleaning tablets, a dental cup, and two dry toothbrushes in the resident's drawer. During an interview at this time, CNA #2 indicated she had not assisted Resident #96 with any type of dental care during her shift.</p> <p>During an interview with the Director of Nursing and Resident #96 on 7/13/11 at 3:55 p.m., Resident #96 indicated she had only been given oral/dental care once since admission which was done once by the dentist when she was seen by him earlier in the week.</p> <p>The facility failed to identify the resident's need for assistance with oral hygiene and ensure care was provided resulting in the resident having poor dental hygiene with red and inflamed soft tissues (gums).</p> <p>Refer to F312 for detailed information related to failure to provide oral hygiene care resulting in actual harm identified during dental exam.</p> <p>2. The clinical record for Resident #81 was reviewed on 7/13/11 at 9:30 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, congestive</p> | | | | |

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| | <p>heart failure and hypertension.</p> <p>A pain assessment, dated 6/25/11 and updated on 7/14/11, indicated Resident #81 was at risk for pain and had experienced pain in the past.</p> <p>During an interview on 7/11/11 at 3:09 p.m., Resident #81 indicated she had a history of chronic back and leg pain.</p> <p>Physician's orders, dated 7/3/11, indicated Resident #81 had an order for a Fentanyl patch 25 mcg/hr (micrograms per hour) to be applied and changed every 3 days. The orders also indicated the resident could have Hydrocodone with acetaminophen (Norco-a narcotic pain medication) 5/325 mg (milligrams) one tablet, two times a day as needed for moderate to severe pain and Zolpidiem Tartrate (Ambien-a hypnotic) 5 mgs at bedtime as needed for insomnia.</p> <p>The "narcotic sign out sheets" for Resident #81 listed the dates and times the "as needed" Norco pain medication was signed out for the resident. Included, but were not limited to, were the following dates and times:</p> <p>7/2/11 at 8 a.m., and 7/8/11 at 8:30</p> | | | | |

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| | <p>a.m.,-the narcotic sign out sheets did not indicate what type of pain the medication was given for or if the medication relieved the resident's pain.</p> <p>The Medication Administration Records for Resident #81, lacked any information related to the Norco medication having been given on the two dates and times noted above. The nursing notes for the dates and times noted above lacked any information related to the pain medication having been given as signed out on the narcotic record.</p> <p>The "hypnotic sign out sheets" for Resident #81 indicated the Ambien medication was signed out for the resident at bedtime on July 1, 2, 3, 4, 7, and 8, 2011. The Ambien medication was only recorded on the MAR as having been given on 7/1, 7/4, and 7/7/11. No information was recorded on the MAR for 7/2, 7/3, and 7/8/11. The nursing notes lacked any information related to the Ambien medication having been given on those three dates or if the medication was effective.</p> <p>b. Resident #95's Clinical Record review was completed on 7/13/11 at</p> | | | | |

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| | <p>2:12 p.m. The resident's diagnoses included, but were not limited to, L4-5 diskus, intercococcus bacteremia, diabetes, neuropathy, and persistent pain.</p> <p>The resident's current physician's orders were signed and dated by the physician on 7/13/11. The orders included an order for hydrocodone-apap [a narcotic pain medication] 5-325 mg, one tablet orally, every four hours as needed for moderate to severe pain. The resident also had an order for zolpidem tartrate [a sleeping pill] 5 mg one tablet orally at bedtime as needed for insomnia.</p> <p>Review of the resident's MAR [Medication Administration Record] for July, 2011 indicated the resident had received hydrocodone-apap 5/325 mg on the following dates: 7/3 - one time 7/4 - three times 7/6 - three times 7/7 - one time 7/8 - one time 7/9 - one time 7/11 - four times 7/12 - three times 7/13 - one time 7/14 - two times</p> | | | | |

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| | <p>Review of the hydrocodone/apap 5/325 mg Controlled Substance Record for July, 2011, indicated the medication had been signed out on the following dates and times:</p> <p>7/1 at 12:15 a.m., 5:30 a.m., 10:30 a.m., and 7:00 p.m. 7/2 at 12:30 a.m., 5:00 a.m., 9:00 a.m., and 5:00 p.m. 7/3 at 12:45 a.m., 4:30 a.m., 10:00 a.m., 3:00 p.m., and 8:00 p.m. 7/4 at 12:00 a.m., 4:00 a.m., 3:45 p.m., and 8:20 p.m. 7/5 at 1:30 a.m., 5:30 a.m., 2:45 p.m., 7:15 p.m., and 11:30 p.m. 7/6 at 4:00 a.m., 9:30 a.m., 1:30 p.m., 5:30 p.m., and 9:30 p.m. 7/7 at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. 7/8 at 1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 4:00 p.m., and 9:00 p.m. 7/9 at 5:00 a.m., 9:00 a.m., 5:00 p.m., and 9:00 p.m. 7/10 at 1:00 a.m., 5:00 a.m., 10:30 a.m., 5:00 p.m., 9:30 and p.m. 7/11 at 1:30 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:20 p.m. 7/12 at 2:45 a.m., 9:00 a.m., 1:30 p.m., 5:45 p.m., and 10:15 p.m. 7/13 at 3:05 a.m., 7:45 a.m., 12:30 p.m., 5:00 p.m., and 9:20 p.m. 7/14 at 3:15 a.m. and 9:30 a.m.</p> <p>The Controlled Substance Record</p> | | | | | | |

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| | <p>indicated the pain medication was signed out for the resident a total of 63 times in July, but was only recorded on the front of the MAR as having been given 20 times. The resident received the medication 43 times without documentation of the medication being given on the MAR.</p> <p>Review of the July, 2011, MAR for zolpidem tartrate 5 mg as needed at bedtime indicated the resident received the medication on 7/3, 7/4, and 7/8.</p> <p>Review of the July, 2011, Controlled Substance Record for the zolpidem tartrate 5 mg indicated the medication was signed out for the resident on 7/1, 7/3, 7/4, 7/5, 7/6, 7/8, 7/9, 7/10, 7/11, 7/12, and 7/13. This indicated the medication was signed out on 8 occasions that were not documented as having been given on the MAR.</p> <p>The facility failed to identify discrepancies between the narcotic sign out sheets and the MAR.</p> <p>Refer to F329 and F428 for detailed information related to discrepancies between records of controlled substance medications.</p> <p>3.a The clinical record for resident</p> | | | | |

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| | <p>#96 was reviewed on 7/13/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #96 included, but were not limited to, diabetes mellitus, depression, and cerebrovascular accident (CVA) with right hemiparesis.</p> <p>A recapitulation of physician's orders, dated 7/3/11, indicated Resident #96 received routine insulin injections three times daily for her diabetes. The orders also indicated Resident #96 was to receive Novolog insulin per sliding scale based on glucose results taken before meals and at bedtime. The sliding scale insulin orders included, but were not limited to, the following:</p> <p>Blood sugar 181-250=give 4 units of Novolog insulin Blood sugar 251-300=give 6 units of Novolog insulin</p> <p>The June and July Medication Administration Records (MAR) lacked documentation of sliding scale insulin having been given based on the glucometer results on the following dates and times:</p> <p>6/2/11 at 6 a.m.-blood sugar 204-no insulin documented as having been</p> | | | | |

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| | <p>given 6/2/11 at 11 a.m. -blood sugar 188-no insulin documented as having been given</p> <p>given 6/3/11 at 11 a.m. -blood sugar 238-no insulin documented as having been given</p> <p>given 6/10/11 at 4 p.m. -blood sugar 218-no insulin documented as having been given</p> <p>given 6/11/11 at 4 p.m.-blood sugar 205-no insulin documented as having been given</p> <p>given 6/11/11 at 8 p.m.-blood sugar 217-the MAR indicated a "zero" for no insulin having been given</p> <p>given 6/20/11 at 4 p.m.-blood sugar 197-no insulin documented as having been given</p> <p>given 6/21/11 at 4 p.m.-blood sugar 199-no insulin documented as having been given</p> <p>given 6/22/11 at 8 p.m.-blood sugar 197-no insulin documented as having been given</p> <p>given 6/25/11 at 4 p.m.-blood sugar 274-no insulin documented as having been given</p> <p>given 6/26/11 at 4 p.m.-blood sugar 190-no insulin documented as having been given</p> <p>given 6/29/11 at 6 a.m.-blood sugar 210-no insulin documented as having been given</p> <p>given 6/30/11 at 11 a.m.-blood sugar 188-no</p> | | | | |

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| | <p>insulin documented as having been given 7/7/11 at 6 a.m.-blood sugar 202-no insulin documented as having been given</p> <p>b. Resident #39's clinical record review was completed on 7/14/11 at 9:42 a.m.</p> <p>The resident's current physician's orders were signed and dated on 6/10/11 by the physician. The resident's diagnoses included, but were not limited to, diabetes mellitus type II and muscle weakness.</p> <p>Resident #39 had a sliding scale insulin coverage order for Humalog 100 units per milliliter to be given subcutaneously for the following blood sugar ranges: 141 - 180 give 1 unit 181 - 220 give 2 units 221 - 260 give 4 units 261 - 300 give 6 units 301 - 340 give 7 units 341 - 380 give 8 units 381 - 420 give 9 units 421 - 460 give 10 units greater than 460 give 12 units.</p> <p>Review of the July, 2011, MAR [Medication Administration Record]</p> | | | | |

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| | <p>indicated Resident #39 had a blood sugar of 146 at 6:00 a.m., on 7/7/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given. The resident had a 6:00 a.m., blood sugar of 159 on 7/9/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given. The resident had a 6:00 a.m., blood sugar of 171 on 7/13/11. The clinical record lacked an indication of 1 unit of Humalog insulin coverage being given.</p> <p>c. The clinical record for Resident #27 was reviewed on 7/12/11 at 9:00 a.m.</p> <p>Resident #27's current diagnoses included, but were not limited to, Schizophrenia, diabetes mellitus, and anxiety.</p> <p>The resident had current physician's orders for the following:</p> <p>Resident #27 had a health care plan, dated 6/11, which indicated the resident had a problem listed as, resident has a diagnosis of diabetes mellitus and blood sugars are unstable. Approaches for this problem included: Monitor blood sugars as ordered, administer medications per order, administer</p> | | | | | | |

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| | <p>insulin per order and oversee available labs.</p> <p>A. Monitor blood sugars two times daily at 6 a.m. and 4 p.m.</p> <p>B. Inject Lantus insulin 70 units at bedtime.</p> <p>C. Inject Novolog insulin according to blood sugar results use sliding scale as follows</p> <p>200-250 = 4 units 251-300 = 6 units 301-350 = 8 units greater than 350 call the physician.</p> <p>Review of the May, and June 2011 Medication Administration Records indicated on the following dates and times Resident #27 did not have her blood sugar monitored as ordered and or received the incorrect sliding scale insulin dose,</p> <p>May</p> <p>May 19 at 6 a.m., no blood sugar result was documented as having been completed</p> <p>May 19, blood sugar was 209 at 4 p.m., no sliding scale insulin was given. The resident should have</p> | | | | |

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| | <p>received 4 units</p> <p>May 29, at 6 a.m., no blood sugar result was documented as having been completed.</p> <p>May 29, blood sugar at 4 p.m., was 380. No sliding scale insulin was documented as having been given. The resident's physician should have been called and insulin orders received for a blood sugar result greater than 350.</p> <p>June</p> <p>June 4th, 6 a.m., blood sugar was 235. No sliding scale insulin was given. The resident should have received 4 units.</p> <p>June 6th, 6 a.m., blood sugar was 215. No sliding scale insulin was given. The resident should have received 4 units.</p> <p>June 15, 6 a.m., No blood sugar result was documented.</p> <p>June 29, 6 a.m., blood sugar result was 205. No insulin was documented as given. The resident should have received 4 units.</p> <p>Refer to F309 for detailed information</p> | | | | |

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| | <p>related to failure to identify inconsistencies in administration or lack of administration of insulin.</p> <p>4. The clinical record for Resident #27 was reviewed on 7/12/11 at 9:00 a.m.</p> <p>Resident #27's current diagnoses included, but were not limited to, Schizophrenia and anxiety.</p> <p>During observation on 7/11/11 at 11:30 a.m., Resident #27 was sitting on her bed in her room. A strong odor was immediately noted. The odor was body odor and/or urine odor.</p> <p>During observation on 7/11/11 at 2:30 p.m., Resident #27 was in her room in her bed. A slight urine odor was noted in the room.</p> <p>During observation on 7/12/11 at 9:00 a.m., a strong urine odor and body odor was noted in the resident's room.</p> <p>A Health care plan, dated 5/1/11, indicated the resident had a problem listed as, requires assist in completing ADL's due to weakness and episodes of incontinence. The goal for the health care plan was the resident will</p> | | | | |

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| | <p>assist with dressing self daily thru next review. Approaches for this problem included: set up clothing and assist resident with dressing and undressing, set up personal hygiene products and assist with oral care, hair care, nail care, a.m. and p.m. care, perineal care, and assist with showers 2 times a week with partials on non-shower days, observe for changes in level of participation with ADL's (activities of daily living) and refer to therapy screening if needed.</p> <p>During an interview on 7/13/11 at 1:20 p.m., with LPN #4, the nurse assigned to care for Resident #27, she indicated the resident was able to take herself to the bathroom and she completed her own peri care. She further indicated the resident did not always "do a good job" with her peri care. LPN #4 indicated she had "occasionally" noted a urine odor in the resident's room. She indicated the CNAs who were assigned to the resident would have to monitor the resident's bathing and toileting needs more closely.</p> <p>Refer to F272 and F315 for detailed information related to the facility's failure to identify the resident's incontinence needs.</p> | | | | | | |

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| | <p>5. The clinical record for Resident #81 was reviewed on 7/13/11 at 9:30 a.m.</p> <p>Diagnoses for Resident #81 included, but were not limited to, congestive heart failure and hypertension.</p> <p>During an interview on 7/11/11 at 3:09 p.m., Resident #81 indicated she had a history of chronic back and leg pain. She indicated she was receiving routine pain medications, but they were not "holding her pain." She was observed during the interview to be making a rocking motion back and forth in her chair. She indicated this movement sometimes helped to relieve her back pain. She indicated it was not yet time for any more pain medication.</p> <p>Physician's orders, dated 7/3/11, indicated Resident #81 had an order for a Fentanyl patch 25 mcg/hr (micrograms per hour) to be applied and changed every 3 days. The orders also indicated the resident could have Hydrocodone with acetaminophen (Norco-a narcotic pain medication) 5/325 mg (milligrams), one tablet, two times a day as needed for moderate to severe pain.</p> <p>An "Interim Care Plan" for Resident</p> | | | | |

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| | <p>#81, dated 6/25/11, indicated she "has pain". The care plan lacked any information related to the type of pain and/or frequency of the pain. The care plan listed one intervention for the pain which was "Fentanyl patch (a narcotic pain patch) every 3 days". The care plan lacked any information of the resident having an order for an "as needed" pain medication.</p> <p>The Interim Care Plan was the only care plan noted in the clinical record.</p> <p>Refer to F279 for detailed information related to the facility's failure to identify the need to develop care plans.</p> <p>6. During an interview on 7/15/11 at 10:00 a.m., the Administrator indicated the facility's quality assurance program had not identified:</p> <p>The failure of the staff to provide oral care as needed for Resident # 96,, sliding scale insulin coverage not being given as ordered by physician for Residents # 96, #39, #27,, narcotics being signed out on narcotics count sheet but not documented as being given on medication administration record</p> | | | | |

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| F9999 | (MAR) for Residents # 81 and # 95,.incontinence care not performed as needed for Resident # 27 or the failure to develop a pain management care plan for Resident # 81. During an interview with the Unit Manager on 7/15/11 at 10:40 a.m., she indicated the nursing staff had not identified the concerns as noted above. 3.1-52(b)(2) | F9999 | F-9999 1.Employees #'s 6, 7, 9, 10 and the O.T. have received 3 hrs of annual dementia training. Employees # 5, 11, 12, 13, 14, | 08/08/2011 | |
| | STATE FINDINGS | | | | |

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| | <p>3.1-14 PERSONNEL</p> <p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 5 of 5 long term employees received 3 hours of annual dementia training (Employees #6, 7, 9, 10, and the Occupational Therapy Assistant) and failed to ensure the 5 of 5 newly hired employees received six hours of initial dementia training. (Employees #5, 11, 12, 13, and 14)</p> | | <p>have received the initial 6 hrs of dementia training.2. Residents residing in the facility have the potential to be affected. Audits were completed of Employee files on 8/5/11 to determine any other employees requiring either 3 hour or 6 hour dementia training.3. During orientation new hires will receive 6 hrs of dementia training to be completed within 30 days of employment. Dementia Training is included on the orientation check-off sheet. Orientation Check-off sheets must be signed off as complete by a supervisor prior to an employee working independently. Annually all employees will be required to complete 3 hrs of dementia training during the month of June. Any employee not having completed the required training by the end of June will be removed from the schedule until the required training is complete.4. DON or designee will audit employee files to ensure dementia training has been provided as indicated. 5 employee files will be audited weekly for 4weeks then, every two weeks for four weeks, then monthly for 4 months, then quarterly until 100% compliance is attained and maintained for two quarters. Audits will be submitted for inclusion in P.I. Program. The P.I. Committee meets monthly and all audits will be reviewed for effectiveness by the committee and revisions made as needed.5.</p> | | |

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| | <p>The employee records were reviewed on 7/14/11 at 3:30 p.m., and lacked an indication of three hours of annual dementia training for the following employees: Housekeeper #6 hired on 5/19/08. Laundry Aide #7 hired on 3/8/85. Occupation Therapy Assistant hired on 8/30/05. LPN #9 hired on 12/6/07. CNA #10 hired on 5/3/94.</p> <p>The employee records lacked indication of six hours of dementia training for the following new hire employees: Cook #5 hired on 6/2/11. LPN #11 hired on 5/17/11. CNA #12 hired on 5/17/11. CNA #13 hired on 5/5/11. CNA #14 hired 5/5/11.</p> <p>During an interview on 7/15/11 at 12:35 p.m., the Director of Nursing indicated the facility had no information to provide related to the lack of dementia training for the employees noted above.</p> <p>3.1-14(u)</p> | | Completion Date: 8/8/11 | | |