

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2016
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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00190495 and IN00190987</p> <p>Complaint IN00190495-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00190987-Substantiated. Federal/State deficiencies related to the allegations are cited at F278, F282, F323, F328, and F514.</p> <p>Survey Dates: January 20, 21, 22, and 25, 2016</p> <p>Facility number: 000083 Provider number: 155166 AIM number: 100289670</p> <p>Census bed type: SNF/NF: 131 Total: 131</p> <p>Census payor type: Medicare: 17 Medicaid: 100 Other: 14 Total: 131</p> <p>Sample: 10</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0278 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on January 31, 2016.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p>			

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	<p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure MDS (Minimum Data Set) assessments were accurate, related to falls and pressure sores, for 3 of 10 residents reviewed for MDS completion in a total sample of 10. (Residents #C, #H, and #M)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 01/21/16 at 12:45 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and dementia with behaviors.</p> <p>New Skin Event forms, dated 10/04/15, indicated the resident had a fluid filled blister on the right heel with measured 4.5 cm (centimeter) by 3 cm, and a fluid filled blister, located on the left heel, which measured at 4 cm by 4 cm.</p>	F 0278	<p>F278 – Assessment Accuracy/Coordination/Certified</p> <p>It is the practice of this provider that the assessment accurately reflects each resident's status.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> A modified MDS has been completed and re-submitted for all three residents identified in this finding <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> All residents have the potential to be affected by this 	02/24/2016

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	<p>A Weekly Update Skin Events form, dated 10/05/15, indicated the resident had an existing area on the coccyx, which was a stage 2 (Partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater), which measured 3.2 cm by 3.5 cm by less than 0.1 cm in depth.</p> <p>A Significant Change in MDS assessment, dated 10/08/15, indicated the resident had no stage 1 (persistent area of skin redness, not opened) or higher unhealed pressure ulcers.</p> <p>During an interview on 01/22/16 at 2:12 p.m., the MDS Nurse indicated the MDS was incorrect.</p> <p>2. Resident #H's record was reviewed on 01/22/16 at 1:55 p.m. The resident's diagnoses included, but were not limited to, mild intellectual disability and diabetes mellitus.</p> <p>The Fall Event forms, dated 12/23/15 at 4:15 a.m., 12/28/15 at 8 a.m., and 01/13/16 at 5:25 a.m., indicated the resident had unwitnessed falls.</p> <p>The Quarterly MDS assessment, dated 01/14/16, indicated the resident had one fall without injury since the last MDS assessment.</p>		<p>finding</p> <ul style="list-style-type: none"> · A facility audit will be conducted by the DNS/designee to ensure that each resident's most recent MDS is accurate including information related to falls and skin conditions · Any inaccuracies noted in this MDS Review will be modified and/or corrected as indicated and re-submitted if necessary <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · MDS Assessments are completed and reviewed during the facility care plan process · Changes in resident condition are reviewed daily during the clinical meetings with information and detailed discussions related to changes such as falls and pressure sores occurring at that time and used when appropriate to complete the MDS Assessment · The DNS/MDS and/or designee will be responsible for review of all resident MDS Assessment information prior to final completion to ensure accuracy and factual information including information related to pressure sores and falls 	

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	<p>During an interview on 01/22/16 at 2:12 p.m., the MDS Nurse indicated the Quarterly MDS was incorrect.</p> <p>3. Resident #M's record was reviewed on 01/25/16 at 9:48 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The Fall Event forms indicated the resident had fallen on 12/09/15 at 7:41 p.m. and had no injuries from the fall, 12/11/15 at 4:52 p.m. and had no injuries from the fall, 12/08/15 at 4:30 p.m. and received a 4 centimeter laceration over the right eye, and 12/20/15 at 3:11 p.m. and had no injuries from the fall.</p> <p>The resident's record indicated a MDS assessment had been completed on 12/03/15.</p> <p>A Significant Change MDS assessment, dated 01/07/16, indicated the resident had a fall/falls since the prior assessment, there was one fall with no injuries and 1 fall with injuries.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the Director of Nursing indicated the Significant Change MDS assessment had been coded incorrectly for falls.</p>		<ul style="list-style-type: none"> · All nursing staff will be in-serviced on or before 2/24/16. This in-service will include review of the policy related to MDS/Assessment completion and accuracy <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing Compliance with this corrective action will be monitored through the facility CQI Program · The DNS/MDS/designee will be responsible for completion of the CQI Tool titled, "RAI Process" weekly for 4 weeks and monthly for 6 months · If threshold of 90% is not met, an action plan will be developed · Findings will be submitted to the CQI Committee for review and follow up <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 2/24/16</p>	

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F 0282 SS=D Bldg. 00	<p>This Federal Tag relates to complaint IN00190987.</p> <p>3.1-31(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician Orders and/or the care plan related to the administration of medications, monitoring blood pressures, and monitoring blood sugars for 3 of 10 residents reviewed for Physician's Orders and care plans, in a total sample of 10. (Resident's #C, #E, and #L)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 01/21/16 at 12:45 p.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease and dementia</p>	F 0282	<p>F282 – Services by Qualified Persons/Per Care Plan</p> <p>It is the practice of this provider that 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Resident #C, #E, #L have been discharged from the facility · All residents are receiving 	02/24/2016

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	<p>with behaviors.</p> <p>The resident's re-admission Physician's Orders, dated 09/08/15, included, carbidopa-levodopa (Parkinson's medication) 25 mg (milligrams)-250 mg, one tablet per gastrostomy tube every four hours and quetiapine (anti-psychotic) 100 mg, two tablets per gastrostomy tube once a day in the evening.</p> <p>The Medication Administration Record (MAR), dated 09/09/15 through 09/30/15, indicated the resident received carbidopa 25 mg every four hours.</p> <p>The MAR, dated 10/2015, indicated the resident received carbidopa 25 mg every four hours 10/01/15 through 10/17/15.</p> <p>A Physician's Order, dated 10/17/15, indicated to discontinue the carbidopa 25 mg and start carbidopa-levodopa 25-250 mg every four hours.</p> <p>The MAR, dated 09/09/15 through 09/30/15, indicated quetiapine 200 mg, one tablet daily. The quetiapine was scheduled for 9 a.m. instead of in the evening as ordered by the Physician.</p> <p>During an interview on 01/21/16 at 4:28 a.m. with the Director of Nursing (DoN)</p>		<p>medications and treatments per physician's order</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by this finding · Physician's Orders have been reviewed for all residents to ensure that all physician's orders have been transcribed correctly to the E-Mar · All resident current E-Mars have been reviewed to ensure all medication have been administered per physician's order, have been given the appropriate dose per physician's order and have been administered within the physician ordered parameters · Any errors and/or discrepancies noted were immediately corrected and promptly reported to physicians and responsible parties <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All new 		

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	<p>and the West Unit Manager, the DoN indicated the order for the carbidopa-levodopa was not transcribed correctly and the resident had not received the medication as ordered. The DoN indicated the quetiapine had not been administered in the evening as ordered by the Physician.</p> <p>2. Resident #E's record was reviewed on 01/22/16 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia and atrial fibrillation.</p> <p>A Physician's Order, dated 12/31/15, indicated orders for Coumadin (blood thinner) 10 mg daily and to discontinue Coumadin 7.5 mg daily.</p> <p>The MAR, dated 12/22/15 through 01/21/16, indicated the Coumadin 7.5 mg was discontinued on 12/31/15 and Coumadin 10 mg daily was ordered. The Coumadin 10 mg was not initialed as given on 12/31/15.</p> <p>The MAR, dated 01/2016, indicated Coumadin 7.5 mg daily and was initialed as given on January 1, 2, and 3, 2016.</p> <p>During an interview on 01/22/16 at 10:30 a.m. with the DoN and the West Unit Manager, the West Unit Manager indicated she had notified the Pharmacy</p>		<p>admissions/re-admission will be reviewed by two licensed nurses and signed by both nurses to verify accuracy at the time of admission</p> <ul style="list-style-type: none"> · The IDT/Nurse Management Team will review and update physician's orders for all admissions, re-admissions, and significant changes during the daily clinical meeting · The Nurse Management Team will review the physician's orders at the start of each month to ensure accuracy per physician's order · Physician orders are reviewed by the Nurse Management Team during the daily clinical meeting and verified for accurate transcription to the E-Mar · A nursing in-service will be conducted on or before 2/24/16. This in-service will include review of the policy related to medication administration, documentation, transcription of physician's orders and following physician's orders <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing Compliance with this corrective action will be 		

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	<p>and 10 mg of Coumadin had not been signed out of the Emergency Drug Kit and the resident had not received the Coumadin 10 mg on 12/31/15. The Director of Nursing indicated the incorrect dose of Coumadin had been administered to the resident on January 1, 2, and 3, 2016. The Director of Nursing indicated the resident received 7.5 mg of Coumadin instead of 10 mg of Coumadin.</p> <p>3. Resident #L's record was reviewed on 01/21/16 at 10:11 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>A care plan, dated 11/16/15, indicated the resident was at risk for hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) due to diabetes. The interventions included, medications as ordered.</p> <p>A care plan, dated 11/16/15, indicated the resident had ineffective tissue perfusion related to hypertension. The interventions included, administer medications as ordered.</p> <p>Physician's Orders, dated 11/13/15, indicated: Accu check (blood sugar check) three times daily before the meal at 5 a.m., 11</p>		<p>monitored through the facility CQI Program</p> <ul style="list-style-type: none"> · The DNS/MDS/designee will be responsible for completion of the CQI Tool titled, "MAR/TAR Review" daily for 4 weeks and weekly for 6 months · If threshold of 90% is not met, an action plan will be developed · Findings will be submitted to the CQI Committee for review and follow up <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 2/24/16</p>		

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	<p>a.m., and 4 p.m.</p> <p>Hydralazine (anti-hypertensive) 50 mg (milligrams), three times a day, if the systolic blood pressure was less than 120 or diastolic blood pressure was less than 60, call the resident's Physician.</p> <p>Metoprolol tartrate (anti-hypertensive) 100 mg, two times a day, if the systolic blood pressure was less than 120 or diastolic blood pressure was less than 60, call the resident's Physician.</p> <p>A Physician's Order, dated 11/18/15, indicated Novolog (insulin) 15 units subcutaneous, hold if blood sugar was less than 120.</p> <p>A Physician's Order, dated 12/04/15, indicated Ambien (hypnotic), 5 mg at bedtime.</p> <p>The MAR and Blood Glucose Monitoring Tool, dated 12/2015, indicated the resident's blood sugar had not been checked on 12/06/15 at 6 a.m., 12/08/15 at 4 p.m., and 12/12/15 at 11 a.m.</p> <p>The MAR, dated 12/2015, indicated the resident's blood sugar was 50 at 11 a.m. on 12/08/15 and 15 units of Novolog was administered. The blood sugar on</p>			

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	<p>12/11/15 at 6 a.m. was 91 and 15 units of Novolog was administered. The blood sugar on 12/11/15 at 4 p.m. was 105 and 15 units of Novolog was administered.</p> <p>The MAR, dated 12/2015, indicated the metoprolol tartrate was scheduled for 9 a.m. and 5 p.m. The resident's blood pressure had not been taken on 12/05/15 at 9 a.m. and 5 p.m., 12/06/15 at 9 a.m. and 5 p.m., 12/09/15 at 9 a.m., 12/12/15 at 9 a.m., 12/13/15 at 9 a.m., and 12/14/15 at 9 a.m.</p> <p>The MAR, dated 12/2015, indicated the hydralazine was scheduled for 9 a.m., 1 p.m., and 5 p.m. The MAR indicated the Blood pressure had not been taken on 12/01/15 at 9 a.m. and 5 p.m., 12/02/15 at 9 a.m. and 5 p.m., 12/09/15 at 9 a.m. and 1 p.m., 12/12/15 at 9 a.m. and 1 p.m., 12/13/15 at 9 a.m., and 12/14/15 at 9 a.m.</p> <p>The MAR, dated 12/2015 indicated the resident's blood pressure on 12/11/15 at 9 a.m. was 110/80 and the metoprolol tartrate and hydralazine was administered and the resident's blood pressure was 110/80 at 1 p.m. on 12/11/15 at 1 p.m. the hydralazine was administered, and 12/12/15 at 5 p.m. the blood pressure was 118/70 and the metoprolol tartrate and hydralazine was administered. The record indicated the Physician had not</p>			

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	<p>been notified of the blood pressures with the systolic below 120.</p> <p>The MAR, dated 12/2015, indicated Ambien, 5 mg was scheduled daily at 9 p.m. The Ambien was initialed and circled on 12/05/15, 12/06/15, 12/08/15, and 12/10/15. The record had not indicated why the Ambien had not been administered as ordered.</p> <p>During an interview on 01/21/16 at 4:12 p.m., with the DoN and the West Unit Manager, the West Unit Manager indicated the Ambien had not been given as ordered and there was no reason documented for not giving the Ambien. The DoN indicated the metoprolol titrate and hydralazine should not have been given with the Physician notified when the systolic blood pressure was lower than 120. The DoN indicated the blood sugars had not been completed and the Novolog insulin was given to the resident with the blood sugar less than 120.</p> <p>This Federal Tag relates to complaint IN00190987.</p> <p>3.1-35(g)(2)</p>			

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F 0323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents, which resulted in injuries from the falls that required sutures for the injuries. (Residents #G and # M). The facility also failed to thoroughly investigate the falls for the root cause and failed to initiate precautions to prevent falls for 4 of 4 residents reviewed for falls, in a total sample of 10. (#C, #G, #H, and #M)</p> <p>Findings include:</p> <p>1. Resident #M's record was reviewed on 01/25/16 at 9:48 a.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 09/04/15, indicated the</p>	F 0323	<p>F323 – Free of Accident Hazards/Supervision/Devices</p> <p>It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Resident # C has been discharged from the facility · Resident #G's fall risk and prevention care plan have been thoroughly reviewed and updated to reflect his current status and specific fall prevention interventions 	02/24/2016

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	<p>resident's cognition was intact, required extensive assistance of two for bed mobility and transfers, had not ambulated, and had one fall without injury and two with injury since the last assessment completed.</p> <p>The care plan, dated 03/23/15, indicated the resident was a risk for falls. The interventions included, 05/20/15-sensor alarm to the bed and 06/24/15-scoop mattress and clip alarm to the wheelchair.</p> <p>The Fall Event form, dated 10/14/15 at 11:30 a.m., indicated the resident was found in the lobby of the facility lying on his left side, and the resident had a bruise to his left shoulder. The resident or witness statement of how the fall occurred indicated the fall was unwitnessed.</p> <p>The Fall Investigation, dated 11/14/15 at 11:30 a.m., indicated the resident fell out of the wheelchair. There was no further investigation documented. The fall investigation had not indicated the resident's wheelchair alarm had been activated with the fall.</p> <p>A Interdisciplinary Team Note (IDT), dated 10/15/15 at 10:56 a.m., indicated the resident was observed on the floor in the front lobby, the resident propels self</p>		<ul style="list-style-type: none"> · Resident #H's fall risk and fall prevention care plan have been thoroughly reviewed and updated to reflect his current status and specific fall prevention interventions · Resident #M's fall risk and fall prevention care plan have been thoroughly reviewed and updated to reflect his current status and specific fall prevention interventions <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents who have been identified as being at risk for falls have the potential to be affected by this finding · A facility audit will be completed by the Nurse Management Team to review all resident fall care plans. The prevention interventions on each resident's fall care plan will be reviewed for accuracy and appropriateness to ensure all interventions are in place and being utilized per the individual plan of care with updates and changes being initiated as indicated · A safety inspection of each resident's room will be completed 	

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	<p>independently throughout the facility and the clip alarm and side tray was in place.</p> <p>During an interview on 0125/16 at 11:29 a.m., the Director of Nursing (DoN), indicated the fall had not been thoroughly investigated for the root cause and the use of the chair clip alarm.</p> <p>The Fall Event form, dated 11/15/15 at 1 a.m., indicated the resident was found sitting on the floor taking his socks off in his room and had received a skin tear to the right hand. The resident or witness statement of how fall occurred, indicated "unwitnessed"</p> <p>The Fall Investigation, dated 11/15/15 at 1 a.m., indicated the resident had a fall resulting in a skin tear to the right hand.</p> <p>The IDT Note, dated 11/16/15 at 10:01 a.m., indicated the resident had been sitting on the floor and taking off his socks and was incontinent.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated she was unsure if the bed alarm had been activated. The DoN indicated the investigation had not included if the fall interventions were in place.</p> <p>The Fall Event Form, dated 11/21/15 at</p>		<p>to ensure that all identified safety interventions and fall prevention interventions are in place and properly being utilized per each resident's individual plan of care</p> <ul style="list-style-type: none"> All new admissions, re-admissions and residents with change in condition or change in safety needs will be identified for fall risk and individual fall precautions will be initiated by Nurse Management/designee per individual need and communicated to direct care staff <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Any fall occurrence will be thoroughly investigated and analyzed for root cause by the IDT/Nurse Management Team using a Fall Investigation worksheet. Fall precautions and safety interventions to prevent another fall occurrence will be initiated immediately based on identification of root cause of the fall The DNS/designee will be notified immediately at the time of the fall to assist in identification of root cause and initiation of prevention interventions A staff in-service will be held on or before 2/24/16. The 	

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	<p>11:30 a.m., indicated the resident was found on the floor in the dining room, had no injuries, and the resident or witness statement of how the fall occurred indicated, "unwitnessed fall"</p> <p>The Fall Investigation, dated 11/21/15 (no time), indicated the Nursing Staff were alerted of the resident's fall by a Housekeeper. There was no investigation if the chair alarm had been activated and the root cause of the fall.</p> <p>The IDT Note, dated 11/23/15 at 9:20 a.m., indicated the resident was in the wheelchair with the lap tray and alarm in place and was noted sitting on buttocks in the main dining room without injuries.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated there had been no investigation for the root cause of the fall and if the chair alarm had been activated.</p> <p>The Fall Event form, dated 12/09/15 at 7:41 p.m., indicated the resident was in his room waiting to go to be and was found on the floor outside of the resident's room with no injuries. The resident statement indicated the resident thought he was going to bed.</p> <p>The Fall Investigation, dated 12/09/15,</p>		<p>DNS/designee is responsible for conducting this in-service. This in-service will review the facility Fall Management Program</p> <ul style="list-style-type: none"> · This in-service will also include review of the importance of adherence to established care plans and safe practices in regards to resident safety and fall prevention · Staff will be re-educated on the importance of providing adequate supervision to residents when indicated to prevent falls as well as appropriate use of individual assistive devices when indicated to prevent falls <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing Compliance with this corrective action will be monitored through the facility CQI Program · The DNS/MDS/designee will be responsible for completion of the CQI Tool titled, "Fall Management" daily for 4 weeks and weekly for 6 months · If threshold of 90% is not met, an action plan will be developed · Findings will be submitted to 	

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	<p>indicated the fall occurred at 7:15 p.m. and 20 minutes prior to the fall the resident had asked to go to bed.</p> <p>The IDT Notes, dated 12/10/15 at 9:05 a.m., indicated the resident was in his room getting ready for bed then the CNA found the resident on the floor. The resident had no shirt, no pants, and his shoes were off. The Root cause of the fall was documented as he doesn't ask for assistance with the transfers and to continue to use the personal clip alarm.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated no one had assisted the resident into bed when he requested to go to bed and the fall was not investigated thoroughly to determine why the staff had not assisted the resident to bed and if the chair alarm had been activated with the fall.</p> <p>The Fall Event form, dated 12/11/15 at 4:52 p.m., indicated the resident was observed walking across the mattress on the floor next to his bed, transferring himself to the wheelchair from the bed and the staff were not able to get to the resident in time to prevent the fall. The Event indicated the staff would be re-educated on the alarm and the alarm was to be turned on when the resident was in bed.</p>		<p>the CQI Committee for review and follow up</p> <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 2/24/16</p>	

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	<p>The Fall Investigation indicated the fall occurred on 12/11/15 at 2:20 p.m., the resident fell on the mattress on his floor and was witnessed. The resident had no injuries.</p> <p>The IDT Note, dated 12/14/15 at 9:30 a.m., indicated the resident had transferred out of bed independently and had walked on the mattress on the floor and fell on the mattress going to the wheelchair. The noted indicated the facility would remove the mattress on the floor and replace it with a mat and replace the sensor alarm with a call light activator bed alarm.</p> <p>During an interview on 01/25/16 at 11:29 a.m. the DoN indicated the resident's bed alarm had not been on and a call light activator bed alarm should have been initiated.</p> <p>The Fall Event form, dated 12/18/15 at 4:30 p.m., indicated the resident was found sitting on the mat on the floor next to the bed and the resident had a 4 centimeter laceration over his right eye. The resident or witness statement of how the fall occurred, indicated the resident stated, "I don't know". The intervention put into place to prevent another fall was a bed alarm with call light activation.</p>			

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	<p>A Nurses' Note, dated 12/18/15 at 5:10 p.m., indicated the resident was transferred to the emergency room.</p> <p>A Nurses' Note, dated 12/18/15 at 8:10 p.m., indicated the resident returned to the facility with seven sutures over the right eye, and the right eye had bruising and swelling.</p> <p>The IDT Note, dated 12/21/15 at 9:29 a.m., indicated the bed alarm had not alarmed, the resident received a laceration over his right eye and received sutures, the root cause of the fall was dementia and the resident attempts to transfer himself out of the bed. The IDT team agreed to bed alarm with call light activation system.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated the alarm had not been on the resident's bed and the call light activated alarm had not been initiated after the fall on 12/11/15.</p> <p>2. Resident #G's record was reviewed on 01/22/16 at 1:16 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and dementia.</p> <p>A Change of MDS assessment, dated 11/24/15, indicated the resident's</p>			

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	<p>cognition was severely impaired, required extensive assistance of two for transfers, and had no falls since the last MDS assessment.</p> <p>A care plan, dated 06/09/15, indicated the resident was a risk for falls. The interventions included, 06/09/15-therapy screen, personal items in reach, non-skid footwear, call light in reach, 06/10/15-Transfer assist of one, 07/30/15-personal alarm in bed, alarm to chair, 12/21/15-scoop mattress, offer to lay the resident down after breakfast and lunch, mat next to bed, and 01/05/16-late bedtime as tolerated.</p> <p>The Fall Event form, dated 12/01/15 at 4:15 p.m., indicated the resident was sitting in his wheelchair by the Nurses' Station playing with the silver cap on the floor and was then found laying on the floor face down. The resident hit his head and bleeding was noted from the forehead and right hand.</p> <p>The Nurses' Progress Notes indicated: 12/01/15 at 4:27 a.m., "Res (resident) fell directly on his face, and sustained laceration to the L. (left) forehead and a skin tear to the R. (right) hand...Transport to (Hospital Name) ER (Emergency Room)..."</p>			

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	<p>12/01/15 at 9 p.m., "Res returned from ER via ambulance...has 8 stitches to the l. (left) eyebrow."</p> <p>The Emergency Department Discharge Instructions, dated 12/01/15, indicated the sutures were to be removed in seven days with a diagnosis of head injury.</p> <p>The Interdisciplinary Team Note, dated 12/02/15 at 9:37 a.m., indicated the resident was playing with the silver cover on the floor prior to the fall, which activated the alarm on the wheelchair, the resident was repositioned back into the wheelchair and the alarm was re-attached. The resident was then found on the front hall with the alarm sounding and was found face down on the floor.</p> <p>The Fall Investigation, dated 12/01/15, indicated the resident fell due to trying to pick up the silver plate off the floor. The Investigation indicated 5-10 minutes prior to the fall the resident was seen trying to grab the sliver, "sewer" covers off the ground (silver plates located on the tile floor), the staff asked the resident to sit back in the hair and the alarm was replaced.</p> <p>There were no interventions initiated to assist in diverting the resident from leaning over and trying to play with the</p>			

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	<p>silver plate cover on the floor after the first attempt of leaning over.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the Director of Nursing (DoN) indicated the resident propels himself in the wheelchair and had went propelled further down the hall when the fall occurred. The DoN indicated when the resident was found leaning over trying to pick up the silver plate from the floor, the staff should have provided the resident with a diversional activity.</p> <p>The Fall Event form, dated 12/19/15 at 3:36 p.m., indicated the resident had an unwitnessed fall and was found lying face down. The resident's alarm was activated at the time of the fall and the resident was sleeping in the wheelchair prior to the fall.</p> <p>The Nurses' Progress Notes, indicated: 12/19/15 at 3:53 p.m., "Responder to alarm sounding. Observed resident lying face down, bleeding from his mouth, nose and forehead. Resident c/o (complains of) back pain. 911 called..."</p> <p>12/19/15 at 6:28 p.m., "resident returned from (Hospital Name). Resident has a fractured nose and split to forehead..."</p> <p>The hospital Discharge Instructions,</p>			

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	<p>dated 12/19/15, indicated diagnoses of head injury and nasal fracture.</p> <p>The Fall Investigation, dated 12/19/15, indicated the resident had an unwitnessed fall on 12/19/15 a 2:50 p.m. The Staff Witness Statement indicated, "When was the last time you assisted the resident before the fall occurred? Put chair alarm back on (no time documented). What did you assist the resident to do when you last provided assistance? Sat resident upright in wc (wheelchair) and put alarm back on..."</p> <p>Another staff statement, dated 12/19/15, indicated at 2:45 p.m. the resident was sleeping in the wheelchair.</p> <p>The Interdisciplinary Team (IDT) Note, dated 12/21/15 at 9:33 a.m., indicated the resident's alarm was sounding and the resident was found lying face down, bleeding from the nose and forehead and the resident was observed sleeping earlier in the wheelchair and the cause of the fall was probably due to the resident sleeping in the chair.</p> <p>The staff did not initiate an intervention to prevent a the fall when he was found sleeping in the wheelchair.</p> <p>During an interview on 01/25/16 at 11:29</p>			

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	<p>a.m., the DoN indicated the staff member who observed the resident sleeping in the wheelchair should have alerted the nursing staff. The DoN indicated she was unsure what time the Nurse had put the chair alarm back on the resident and sat the resident upright in the wheelchair.</p> <p>The Fall Event form, dated 12/21/15, at 4:24 a.m., indicated the resident had an unwitnessed fall and was found lying on the floor off of the mattress.</p> <p>The Fall Investigation, dated 12/21/15, indicated the resident was lying on the floor in the room, off the mattress next to the bed. The statement from the staff form was left blank.</p> <p>The IDT Note, dated 12/21/15 at 9:47 a.m. indicated the resident had been sleeping since 10:30 p.m. , the alarm was activated, and the staff observed the resident lying on the floor.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated there was no investigation to determine the root cause of the fall.</p> <p>The Fall Event form, dated 01/04/16 at 3:33 a.m., indicated the alarm was sounding and the resident was found on the floor next to the bed and had a left</p>			

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	<p>elbow laceration and a wound on the right knee re-opened.</p> <p>The Fall Investigation, dated 01/04/16, indicated the resident was found on the floor. A staff statement indicated the last time the resident was assisted was at 3 a.m. when the resident's alarm was sounding and the resident was sitting on the bedside. The staff member indicated they assisted the resident to lay back down in the bed.</p> <p>The IDT note, dated 01/05/16 at 9:26 a.m., indicated the resident was transferring himself without assistance.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated there was no investigation to determine the root cause of the fall or an intervention used when the resident was found sitting up in the bed 30 minutes prior to the fall to assist in preventing the fall.</p> <p>3. Resident #H's record was reviewed on 01/22/16 at 1:55 p.m. The resident's diagnoses included, but were not limited to, mild intellectual disability and diabetes mellitus.</p> <p>A Quarterly MDS assessment, dated 10/20/15, indicated the resident's cognition status was severely impaired,</p>			

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	<p>required extensive assistance of two or more staff for bed mobility and transfers, and had no falls since the last MDS assessment.</p> <p>The Fall Event form, dated 12/18/15 at 8 a.m., indicated the resident was found sitting on the floor next to the bed in the room. The area which stated, "Resident or witness statement of how fall occurred", indicated "unknown". The fall follow up notes indicated: 12/18/15 at 8:20 a.m., "Resident had a unwitnessed fall. Res. (resident) was sitting on floor next to bed, assisted with staff getting resident to bed...Resident appears to be sleepy..." 12/21/15 at 9:36 a.m., "IDT (Interdisciplinary Team) team to met (sic) to review fall on 12-18-15 in the morning. Resident had an unwitnessed fall...Position rails will be applied to bed..."</p> <p>The fall investigation, dated 12/18/15, indicated the resident had an unwitnessed fall in the room and was found sitting on the floor next to the bed.</p> <p>During an interview on 01/26/16 at 11:29 a.m., the DoN indicated the fall had not been investigated for the root cause of the fall.</p>			

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	<p>The Fall Event form, dated 12/23/15 at 4:15 a.m., indicated the resident had an unwitnessed fall and was found sitting upright on the floor next to the bed. The form indicated the resident had attempted to transfer independently from the bed to the wheelchair.</p> <p>The Nurses' Progress Note, dated 12/23/15 at 4:50 a.m., indicated the resident stated he fell from the bed.</p> <p>The Investigation of the fall, dated 12/23/15 at 4:15 a.m., indicated the fall occurred when the resident had transferred from the bed to the chair independently. There was no investigation as to why the resident had attempted to transfer independently or why the resident was wanting out of bed and into the chair.</p> <p>The Staff Statement Worksheet indicated the fall was unwitnessed, there was no time listed when the staff last assisted the resident and when the resident was last toileted.</p> <p>During an interview on 01/25/16 at 11:29 a.m., the DoN indicated the investigation had not been thoroughly investigated to determine a root cause for the fall.</p> <p>4. Resident #C's record was reviewed on</p>			

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	<p>01/21/16 at 12:45 p.m. The resident's diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>An Admission MDS assessment, dated 08/06/15, indicated the resident's cognition was intact, required extensive assistance of one for bed mobility and extensive assistance of two for transfers, required supervision of ambulation, and had one fall without injury.</p> <p>The Fall Event form, dated 09/08/15 at 6:27 p.m., indicated the resident was found on the floor in his room with a small amount of blood present, with a 2 x 3 (centimeter) scab to his forehead and the resident stated he was trying to get up.</p> <p>The Post Fall Investigation, dated 09/08/15, 3-11 (p.m.) shift, indicated, "...What was the resident doing or attempting to do at the time of the fall? self transfer..."</p> <p>The Fall Event form, dated 09/08/15 at 10:30 p.m., indicated the resident was sitting in a chair at the Nurses' Station and was then found on the floor lying on his left side by the West Dining Room. There was no injuries seen and the resident was sent to the Hospital Emergency Room for an evaluation.</p>			

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	<p>The Post Fall Investigation, dated 09/08/15, 3-11 shift, indicated the resident had attempted to get out of the wheelchair.</p> <p>A Hospital CT of the cervical spine report, dated 09/09/15 at 1:31 a.m., indicated there was a probable non displaced fracture of the C2 (neck) vertebral body.</p> <p>A Interdisciplinary Team Note, dated 09/09/15 at 9:47 a.m., indicated the resident was found lying on the floor in his room. The resident stated he was trying to get out of bed. The resident was assisted into a wheelchair and brought to the Nurses' Station. He was noted on the floor by the wheelchair and complained of hip pain and was sent to the Emergency Department for an evaluation.</p> <p>During an interview on 01/25/16 11:29 a.m., the DoN indicated the investigation had not included the root cause of why the resident was attempting to get up on his own.</p> <p>A facility policy, dated 02/2015, titled, "Fall Management Program", received from the ADoN as current, indicated, "...Post fall...A fall event will be initiated as soon as the resident has been assessed</p>			

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F 0328 SS=D Bldg. 00	<p>and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls..."</p> <p>This Federal Tag relates to complaint IN00190987.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:</p>			

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	<p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed ensure residents received proper treatment, related to gastrostomy (g-tube) feedings not infusing at the rate as ordered by the Physician for 2 of 4 residents reviewed for g-tube feedings in a total sample of 10. (Residents #E and #F)</p> <p>Findings include:</p> <p>1. Resident #E's record was reviewed on 01/22/16 at 9:50 a.m. The resident's diagnoses included, but were not limited to, dementia, g-tube tube, and atrial fibrillation.</p> <p>During an observation on 01/20/16 at 4:10 p.m., 01/21/16 at 8:27 a.m. and 5:29 p.m., and 01/22/16 at 8:03 a.m. and 10:27 a.m., Resident #E was lying in bed with the g-tube feeding being administered at 75 cc (centimeters) per hour.</p> <p>A Nutrition at Risk (NAR) Progress Note, dated 01/13/16 at 3 p.m., indicated</p>	F 0328	<p>F328 – Treatment/Care for Special Needs</p> <p>It is the practice of this provider to ensure that residents receive proper treatment and care for special services.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Resident #E has been discharged from the facility · Resident #F's physician and family have been notified of this resident's current enteral therapy orders. This resident is receiving enteral therapy at the physician ordered rate <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · Any resident with enteral therapy orders has the potential to be affected by this finding 	02/24/2016

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	<p>the resident had been consuming 25-100% of breakfast, lunch and dinner by mouth and was receiving a tube feeding of Glucerna (liquid feeding) 1.5 cal (calorie per cc) at a rate of 55 cc an hour for 22 hours a day. The recommendation was to change the tube feeding to 75 cc per hour for 12 hours a day to help promote eating by mouth.</p> <p>A Physician's Order, dated 01/13/16, indicated to discontinue the Glucerna 1.5 feeding at 55 cc's an hour and to start Glucerna 1.5 at 75 cc per hour for 12 hours, on at 7 p.m. and off at 7 a.m.</p> <p>During an interview on 01/22/16 at 10:27 a.m., LPN #1 indicated the resident's Glucerna 1.5 was infusing at 75 cc's an hour.</p> <p>During an interview on 01/22/16 at 10:30 a.m. with the Director of Nursing and the West Unit Manager, the Director of Nursing indicated the g-tube feeding should be infusing at 75 cc's an hour for 12 hour. She indicated the E-MAR (Electronic Medication Administration Record) indicated the Glucerna 1.5 was to be administered at 55 cc's an hour for 22 hours, on at 7 a.m. and off at 5 a.m.</p> <p>2. During an observation on 01/20/16 at 4:29 p.m., 01/21/16 at 8:29 a.m. and 5:29</p>		<ul style="list-style-type: none"> · A facility audit of all residents with orders for enteral therapy will be completed by the DNS/Nurse Management Team. This audit will ensure that all residents are receiving their enteral feedings at the physician ordered rate · Any errors and/or discrepancies noted during this audit will be corrected and/or clarified immediately · All new admissions/re-admissions and physician's orders are reviewed during the daily clinical meetings – any new orders or changed physician orders related to enteral feedings will be verified as correct by two licensed nurses against the E-Mar · Rounds are completed each shift by the Charge Nurse and/or Unit Manager/designee to monitor that enteral feedings are properly infusing at the physician ordered rate <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All new admissions/re-admissions and physician's orders are reviewed during the daily clinical meetings 	

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	<p>p.m., and 01/22/16 at 8:05 a.m. and 1:04 p.m., the resident was lying in bed with the g-tube feeding infusing at 60 cc's an hour.</p> <p>Resident #F's record was reviewed on 01/22/16 at 12 p.m. The resident's diagnoses included, but were not limited to, muscular dystrophy and dysphagia.</p> <p>A NAR Progress Note, dated 12/23/15 at 1:16 p.m., indicated the resident's weight was 102 and was underweight. The note indicated the resident's tube feeding had been changed back to 24 hours per day due to the resident had refused to eat. The note indicated a recommendation to increase the feeding to 65 cc's an hour to assist with weight gain.</p> <p>A Physician's Order, dated 12/24/15, indicated an order for Jevity 1.5 at 65 cc's per hour continuously.</p> <p>The E-MAR, dated 01/2016, indicated by initials, the resident had been receiving the Jevity 1.5 at 65 cc's an hour.</p> <p>During an interview on 01/22/16 at 1:04 p.m., the West Unit Manager indicated the resident's G-tube feeding was being infused at 60 cc an hour and it should be infused at 65 cc's an hour.</p>		<p>– any new orders or changed physician orders related to enteral feedings will be verified as correct by two licensed nurses against the E-Mar</p> <ul style="list-style-type: none"> · Rounds are completed each shift by the Charge Nurse and/or Unit Manager to monitor that enteral feedings are properly infusing at the physician ordered rate · A nursing in-service will be conducted on or before 2/24/16. This in-service will include review of the policy related to enteral feeding administration, documentation, transcription of physician's orders related to enteral feedings and following physician's orders related to enteral feedings <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing Compliance with this corrective action will be monitored through the facility CQI Program · The DNS/MDS/designee will be responsible for completion of the CQI Tool titled, "Enteral Therapy" daily for 4 weeks and weekly for 6 months · If threshold of 90% is not 	

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F 0514 SS=D Bldg. 00	<p>A facility policy, dated 01/2015, titled, "Enteral Therapy" and received from the Assistant Director of Nursing as current, indicated, "...A licensed nurse will take, note, and implement physician orders for enteral therapy..."</p> <p>This Federal Tag relates to complaint IN00190987.</p> <p>3.1-47(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record</p>		<p>met, an action plan will be developed</p> <p>· Findings will be submitted to the CQI Committee for review and follow up</p> <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 2/24/16</p>	

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	<p>of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure a resident's record was complete and readily accessible, related to unable to locate a Medication Administration Record (MAR) for 1 of 10 residents reviewed for medication and treatment administration in a total sample of 10. (Resident #C)</p> <p>Finding includes:</p> <p>Resident #C's record was reviewed on 01/21/16 at 12:45 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and dementia with behaviors. The resident was discharged from the facility on 12/04/15.</p> <p>Resident #C's MAR's, dated 09/2015, 10/2015, and 11/2015 were reviewed for accuracy.</p> <p>During an interview on 01/21/16 at 5:45 p.m., 01/22/16 at 10:30 a.m., and 01/25/16 at 12:09 p.m., the Director of Nursing indicated the 12/2015 MAR for Resident #C could not be found.</p> <p>This Federal Tag relates to complaint IN00190987.</p>	F 0514	<p>F514 – Records-Complete/Accurate/Ac cessible</p> <p>It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> · Resident #C has been discharged from the facility · The facility has recently undergone transition to the Electronic Medication Pass and individual resident MARs are now a part of the Electronic Medical Record and readily available and accessible <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> · All residents have the 	02/24/2016

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	3.1-50(a)(1) 3.1-50(a)(3)		<p>potential to be affected by this finding</p> <ul style="list-style-type: none"> An audit has been completed on all resident current medical records to ensure that all are current and readily accessible Medical Records is responsible for thorough audits of all discharged resident clinical records to ensure all necessary documents including Medication Administration Records are completed and readily accessible for each discharged resident <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> A nursing in-service will be conducted by the DNS/designee on or before 2/24/16. This in-service will review the facility policy related to maintenance of the resident's clinical record including new practices related to storage and maintenance of documents in the Electronic Medical Record Medical Records/designee is responsible for running E-Mar Compliance Reports Monday through Friday to ensure resident's clinical records are complete and readily accessible <p>How the corrective action(s)</p>	

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			<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · Ongoing Compliance with this corrective action will be monitored through the facility CQI Program · The DNS/MDS/designee will be responsible for completion of the CQI Tool titled, "Ongoing Medical Records" weekly for 4 weeks and monthly for 6 months · If threshold of 90% is not met, an action plan will be developed · Findings will be submitted to the CQI Committee for review and follow up <p>By what date the systemic changes will be completed:</p> <p>Compliance Date = 2/24/16</p>	