

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
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NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: October 26, 27, 28, 29, 30, November 2, 4, and 5, 2015.</p> <p>Facility number: 000029 Provider number: 155072 AIM number: 100275200</p> <p>Census bed type: SNF: 11 SNF/NF: 93 Residential: 15 Total: 119</p> <p>Census payor type: Medicare: 12 Medicaid: 77 Other: 15 Total: 104</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14466 on November 09, 2015.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0257 SS=E Bldg. 00	<p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interview, the facility failed to to maintain a comfortable and safe temperature range of 71-81 degrees Fahrenheit for 104 residents who reside in the facility.</p> <p>Findings include:</p> <p>During a stage 1 interview on 10/27/15 at 3:52 p.m., Resident #114 indicated the Main Dining room and 200 hall temperatures were cool.</p> <p>On 11/4/15 at 11:00 a.m., during environmental tour the following temperatures were measured in the common areas of the facility:</p> <ol style="list-style-type: none"> 1. In the Meadows Dining Room the temperature was 65 degrees Fahrenheit. 2. In the Main Dining Room the temperature was 66 degrees Fahrenheit. 3. The temperature in the 100 hall located near resident room 101 was 68 degrees 	F 0257	<p>F 257</p> <ol style="list-style-type: none"> 1. Temperature was readjusted on units to range from 71-81 degrees. 2. Residents residing near rooms 101, 212, and 114, and residents in Main dining room and companion dining room have the potential to be affected by the alleged deficient practice. An audit of the residents within those areas were interviewed and no complaints of noted. The ED and/or Designee will conduct a maintenance staff in-service on proper temperature requirements on November 10th and ongoing. 3. The ED and/or Designee will conduct a maintenance staff in-service on proper temperature requirements on November 10th and ongoing. Thermometers will be placed periodically throughout facility to assist in monitoring temperatures. The maintenance supervisor or designee will round each shift to 	11/20/2015

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	<p>Fahrenheit.</p> <p>4. The temperature in the 100 hall located near resident room 114 was 69 degrees Fahrenheit.</p> <p>5. The temperature in the 200 hall located near resident room 212 was 68 degrees Fahrenheit.</p> <p>During an interview on 11/4/15 at 11:45 a.m., the Maintenance Supervisor indicated he set the thermostats to an appropriate temperature between 71-74 degrees Fahrenheit. He checked the temperatures monthly, but had no documentation of temperatures taken in common areas.</p> <p>During an interview on 11/5/15 2:15 p.m., the Executive Director indicated to manage appropriate safe and comfortable temperature within the common areas of the building at Beech Grove Meadows the following is standard operating procedure is utilized:</p> <p>1. Thermostats within the building are set to an appropriate temperature between 71-74 degrees Fahrenheit.</p> <p>2. Thermostats within the building are set by Maintenance department and are secured with a key lock so that the appropriate set temperatures are maintained.</p> <p>3. Preventative checks of this system are</p>		<p>ensure appropriate temperatures indesignated areas throughout the facility.</p> <p>4.To ensure compliance the ED/Designee is responsiblefor completion of environmental rounds audit tool. The tool will be completedfor 6 months with audits being completed daily x 1 week, weekly x 4 weeks,bimonthly x 2 months and monthly x 3 months. The results of these audits willbe reviewed by the CQI committee monthly for 6 months after which the CQI teamwill re-evaluate the continued need for the audit. If threshold of 100% is not achieved anaction plan will be developed to assure compliance. Deficiency in this practicewill result in disciplinary action up to and including termination of theresponsible employee.</p>	

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F 0278 SS=D Bldg. 00	<p>conducted monthly and as needed.</p> <p>4. Complaints or concerns are addressed immediately by the maintenance Director by evaluating the set temperature of the thermostats.</p> <p>Review of facility census dated 10/26/15, indicated 104 residents.</p> <p>3.1-19(h)</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> <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</p>			

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	<p>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 interview and record review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for medications. (Resident # 74 and Resident #28)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #74 was completed on 10/29/15 at 10:26 a.m. Diagnoses included, but were not limited to, anxiety and depressive disorder.</p> <p>The quarterly MDS assessment Section N0410 B completed on 9/30/15, assessed Resident #74 as not receiving and anti-anxiety medication. This assessment was signed by an RN (registered nurse) Coordinator on 10/14/15</p> <p>A review of the Medication Administration Record for 9/24/15 through 9/30/15, for Resident #74 for 7 days prior to the quarterly MDS assessment, indicated Resident #74 received lorazepam (medication used for</p>	F 0278	<p>F 278</p> <p>1. Resident# 74 and #28 MDS assessment was corrected and modified by 11-3-15.</p> <p>2. All residents who reside in the facility and receive psychotropic medications are at risk for the alleged deficient practice. A current Resident audit will be conducted by MDS/Designee for past 3 months to determine accurate coding of psychosocial medications. Any discrepancies noted will be modified as needed. The MDS Consultant and/or Designee will conduct MDS staff in-service on accurate coding of psychosocial medications for MDS assessment on November 16th and ongoing.</p> <p>3. The MDS Consultant and/or Designee will conduct MDS staff in-service on accurate coding of psychosocial medications for MDS assessment on November 16th and ongoing. MDS' will be reviewed on a weekly basis using the care plan schedule. The IDT team will utilize the care plan guideline review tool during</p>	11/20/2015

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	<p>anxiety) on September 24, 25, 26, 27, 28, 29, and 30.</p> <p>During an interview on 11/2/15 at 11:44 a.m., the MDS Assistant indicated the MDS assessment dated 9/30/15, was coded incorrectly and should have been coded to indicate the resident did receive an anti-anxiety medication.</p> <p>The Resident Assessment Instrument Comprehensive User Manual, Version 3.0, copy right 2009, page 479 indicated, "...B. antianxiety, lorazepam is an antianxiety medication...."</p> <p>2. The clinical record of Resident #28 was reviewed on 10/30/15 at 12:58 p.m. Diagnoses for the resident included, but were not limited to, depressive disorder.</p> <p>Recapitulated physician's orders for September, 2015, indicated Resident #28 was to receive mirtazapine 15 milligrams (mg) daily at bedtime (original order date 4/30/15), and trazodone 150 mg daily at bedtime.(original order date 7/2/15 Mirtazapine and trazodone are antidepressant medications.</p> <p>A Medication Administration Record for September, 2015, indicated the resident received mirtazapine and trazodone daily at bedtime.</p>		<p>IDTmeeting. The IDT team will ensure all MDS coding for psychosocial medicationsare accurate.</p> <p>4.To ensure compliance the DNS/Designee isresponsible for completion of RAI CQI tool. The tool will be completed for 6months with audits being completed weekly x 4 weeks, bimonthly x 2 months andmonthly x 3 months. Any MDS assessmentsfound to be out of compliance during audits will be immediately corrected. Therresults of these audits will be reviewed by the CQI committee monthly for 6months after which the CQI team will re-evaluate the continued need for theaudit. If threshold of 100% is notachieved an action plan will be developed to assure compliance. Deficiency in thispractice will result in disciplinary action up to and including termination ofthe responsible employee.</p>		

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F 0315 SS=D Bldg. 00	<p>A care plan dated 11/23/13 and current through 12/23/15, indicated the resident was at risk for adverse side effects related to the use of psychotropic medications for depression.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/21/15, indicated Resident #28 did not receive any antidepressant medications during, "the last 7 days." This assessment was signed by the RN Assessment Coordinator on 10/1/15.</p> <p>On 10/30/15 at 3:00 p.m. the RN Assessment Coordinator indicated the 9/21/15 MDS documentation regarding Resident #28 not receiving any antidepressants during the assessment period was in error.</p> <p>3.1-31(i) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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</p>				

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	<p>possible. Based on observation, record review, and interview, the facility failed to ensure indwelling urinary catheter drainage bags were maintained in a manner to prevent urinary tract infection for 2 of 2 residents observed for care of urinary catheter drainage bags. (Residents #200 and #171)</p> <p>Findings include:</p> <p>1. A clinical record review for Resident #200 on 11/2/15 at 1:00 p.m., indicated a diagnosis of enlarged prostate. A physician's order dated 10/21/15, indicated the resident had an indwelling urinary catheter.</p> <p>On 11/2/15 at 11:19 a.m. the urinary catheter drainage bag was observed dragging along the floor as the resident was being transported in a wheel chair down the hallway in the rehabilitation unit.</p> <p>On 11/4/15 at 2:35 p.m. the Director of Nursing Services indicated urinary catheter bags should be kept off the floor to prevent increased opportunity for urinary tract infections.</p> <p>2. A clinical record review for Resident #171 completed on 10/27/15 at 11:15</p>			F 0315	<p>F 315</p> <p>1. Resident # 171 catheter was positioned properly on the bed. Resident no longer resides in the facility. Resident # 200 catheter was repositioned properly on wheelchair. Resident no longer resides in the facility. Staff on duty was immediately educated on placement of catheter.</p> <p>2. All residents who reside in the facility and have catheters have the potential to be affected by the alleged deficient practice. An audit of the residents with catheters found them all to be hanging from bed or wheelchair in privacy bags that do not touch the ground.</p> <p>1. The CEC and/or Designee will conduct a staff in-service on catheter care including handling of catheter bags on November 17th and ongoing. The DNS or designee will round each shift daily to ensure catheter tubing is placed appropriately in privacy bags and ensure the tubing does not touch the ground. Results of those rounds will be included in the Catheter Audit Tool and reviewed as delineated below.</p> <p>2. To ensure compliance the DNS/Designee is responsible for completion of the Catheter Audit Tool. The tool will be completed for 6 months with audits being completed weekly x 4 weeks, bimonthly x 2 months and monthly</p>		11/20/2015

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R 0000 Bldg. 00	<p>a.m., indicated a diagnoses of obstructive uropathy. A physician's order dated 7/30/15, indicated the resident had an indwelling urinary catheter.</p> <p>During an observation on 10/26/15 at 2:30 p.m., Resident #171's catheter drainage bag was observed resting on the floor.</p> <p>During an interview with the Director of Nursing Services (DNS) on 11/4/15 at 3:15 p.m., the DNS indicated catheter drainage bags are not to be touching the floor.</p> <p>On 11/2/15 at 2:09 p.m., a policy regarding indwelling urinary catheter drainage bag care was requested. No policy was provided by exit on 11/5/15 at 3:25 p.m.</p> <p>3.1-41(a)(2)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Resident census: 15 Sample: 7</p>	R 0000	<p>x 3 months The results of these audits will be reviewed by the CQI committee monthly for 6 months after which the CQI team will re-evaluate the continued need for the audit. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>				

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R 0092 Bldg. 00	<p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift, for 15 residents who reside in the facility.</p> <p>Findings include: Review on 11/4/15 at 12:45 p.m., of</p>	R 0092	<p>R092 1.Night shift fire drill was completed 2.Residents residing on the Assisted Living unithave the potential to be affected by the alleged deficient practice</p>	11/20/2015

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R 0217 Bldg. 00	<p>Beech Grove Meadows Fire Drill documentation from October 2014 to October 2015, lacked documentation of a fire drill for third shift for the fourth quarter (October, November, and December) of 2014 and the first quarter (January, February, and March) of 2015.</p> <p>During an interview on 11/4/15 at 1:45 p.m., the Executive Director indicated they did not have documentation of the missing fire drills. The Executive Director indicated they had provided all the documentation on the fire drills they had.</p>				<p>3. The ED and/or Designee will conduct amaintenance staff in-service on fire drills including every shift every quarterdrills. The maintenance supervisor will follow the PMI checklist and completefire drills once monthly on different shifts ensuring all shifts are coveredeach quarter. The ED or designee willreview the fire drill log once monthly during safety meeting</p> <p>1. To ensure compliance the MaintenanceSupervisor/Designee is responsible for completion of the Fire Drill audit tool. The tool will be completed for 6 months with audits being completed weekly x 4weeks, bimonthly x 2 months and monthly x 3 months The results of these auditswill be reviewed by the CQI committee monthly for 6 months after which the CQIteam will re-evaluate the continued need for the audit. If threshold of 100% is not achieved anaction plan will be developed to assure compliance. Deficiency in this practicewill result in disciplinary action up to and including termination of theresponsible employee.</p>		
	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual						

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	<p>resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure a service plan was implemented in that a resident did not receive a medication ordered by the physician for 1 of 5 residents reviewed for implementation of service plans. (Resident #309)</p> <p>Findings include:</p> <p>The clinical record of Resident #309 was reviewed on 11/4/15 at 2:10 p.m. Diagnoses for the resident included, but were not limited to, high blood pressure and coronary artery disease.</p>	R 0217	<p>R217</p> <p>1.MD notified about missed medications for resident# 309. No new orders were received. Resident #309 BP was checked every shift x72 hours. Med error documentation was completed and the assigned nurseseducated on reconciliation of monthly rewrites on or before November 11-20-15.</p> <p>2.All residents receiving rewrites from Pharamkonhave the potential to be affected by the alleged deficient practice. A full audit was conducted on all residentswho receive Phamakon</p>	11/20/2015	

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	<p>A service plan for Resident #309, dated 7/14/15, indicated assistance with and administration of medications was required daily. On 11/5/15 at 2:10 p.m., the Clinical Director indicated this was the current service plan for the resident.</p> <p>A physician's order dated 7/14/15, indicated the resident was to receive metoprolol 12.5 milligrams (mg) twice a day for high blood pressure. Review of Medication Administration Records (MAR) for October 2015, indicated the resident received metoprolol as ordered 2 times per day.</p> <p>The MAR for November 2015, indicated the resident did not receive any metoprolol on November 1, 2, 3, nor 4, 2015. No documentation was found in the resident's record which indicated the physician had discontinued the metoprolol.</p> <p>On 11/4/15 at 3:00 p.m. the Clinical Director (CD) indicated the order for the Metoprolol did not get carried over to the November, 2015, recapitulated physician orders on the November, 2015 MAR. The CD indicated the pharmacy always sent a new set of recapitulated orders each month, and the nurses compared the previous months orders to the new orders</p>		<p>rewrites and no other issues were noted. The DNS and/or Designee will conduct a staff in-service on completion of med reconciliation with the rewrites on or before 11-20-15.</p> <p>1. The DNS and/or Designee will conduct a staff in-service on completion of med reconciliation with the rewrites. To ensure compliance the DNS/Designee is responsible for random review of monthly rewrites. Daily orders will be read at morning clinical meeting and orders will be written on current MAR and sent to pharmacy medical records for transcription. Monthly rewrite checks will be completed by 2 staff members with oversight of DNS/Designee for corrections.</p> <p>2. To ensure compliance the DNS/Designee is responsible for completion of physician orders/rewrite audit tool. The tool will be completed for 6 months with audits being completed weekly x 4 weeks, bimonthly x 2 months and monthly x 3 months. The results of these audits will be reviewed by the CQI committee monthly for 6 months after which the CQI team will re-evaluate the continued need for the audit. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
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R 0349 Bldg. 00	<p>to make sure the orders were accurate. She indicated, "We missed it [the metoprolol order] when we were checking orders."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure laboratory requisition records were accurately documented (Resident #316), month-to-month physician recapitulated orders were accurately documented (Resident #309), and a resident's daily blood pressures were legibly documented (Resident #303) for 3 of 7 residents reviewed.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #316 was reviewed on 11/4/15 at 11:45 a.m. Diagnoses included, but were not limited to, hypertension and depression.</p>	R 0349	<p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> <p>R349 1.Issue #1- Res #316 MD was notified of missing lab and no new orders were received. Clinical Director educated per teachable moment on checking lab requisitions prior to drawing labs to ensure orders are in place on or before 11-20-15. Issue#2 - MD was notified about resident # 309s missed medication. The residents MAR was updated. No new orders were received. Resident #309 BP was checked every shift x 72hours. Med error documentation was completed and the assigned nurses educated on reconciliation of monthly rewrites on or before 11-20-15. Issue#3 - Resident # 303s BP</p>	11/20/2015

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	<p>A review of Resident #316's clinical record, lacked a physician's order to draw a Basic Metabolic Panel (BMP) lab on 8/24/15.</p> <p>Laboratory results for Resident #316 indicated a BMP lab was completed on 8/24/15.</p> <p>A review of the final laboratory requisitions dated 8/24/15, listed Resident #316's name twice. One of the names included a different birth date and was crossed off and the correct birth date for Resident #316 was wrote above the incorrect birth date.</p> <p>On 11/5/15 at 10:38 a.m., the Clinical Director indicated the laboratory sends a preliminary report to the facility that contains the scheduled lab draws to be completed for the next day. The nurse is to check the preliminary report for accuracy and notify the laboratory if discrepancies are found. Lab then sends a final report to the facility. The Clinical Director the BMP would have been removed from the lab requisition list if the preliminary report was checked correctly by the facility staff. The Clinical Director indicated the BMP lab should not have been completed on 8/24/15 for Resident #316.</p>		<p>was monitored, documented and was within normal limits. The DNS/Designee will educate AL nursing staff on new vitals/BP flowsheets and to have legible documentation on or before 11-20-15.</p> <p>2.All residents receiving labs from Medlab had thepotential to be affected by the alleged deficient practice. Residents receiving rewrites from Pharamkonhad the potential to be affected by the alleged deficient practice . Residents with BP monitoring have thepotential to be affected by the alleged deficient practice. A full audit was conducted on all residentswho receive Phamacon rewrites and no other issues were noted. Lab audit to be conducted on 11-19-15 toensure orders are accurate. Allresidents on BP monitoring were audited to ensure accurate and legibledocumentation.</p> <p>1.The DNS/Designee will educate all AL nursingstaff on lab monitoring on or before 11-20-15. The DNS and/or Designee willconduct a staff in-service on completion of med reconciliation with therewrites on or before 11-20-15. TheDNS/Designee will educate AL nursing staff on new vitals/BP flow sheets and tohave legible documentation on or before 11-20-15. To ensure compliance theDNS/Designee is</p>	

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	<p>2. The clinical record of Resident #309 was reviewed on 11/4/15 at 2:10 p.m. Diagnoses for the resident included, but were not limited to, high blood pressure and coronary artery disease.</p> <p>A physician's order dated 7/14/15, indicated the resident was to receive metoprolol 12.5 milligrams (mg) twice a day for high blood pressure. Review of Medication Administration Records (MAR) for October 2015, indicated the resident received metoprolol as ordered 2 times per day.</p> <p>The MAR for November 2015, indicated the resident did not receive any metoprolol on November 1, 2, 3, nor 4, 2015. No documentation was found in the resident's record which indicated the physician had discontinued the metoprolol.</p> <p>On 11/4/15 at 3:00 p.m. the Clinical Director (CD) indicated the order for the Metoprolol did not get carried over to the November, 2015 recapitulated physician orders on the November, 2015, MAR. The CD indicated the pharmacy always sent a new set of recapitulated orders each month, and the nurses compared the previous months orders to the new orders to make sure the orders were accurate.</p>		<p>responsible for random review of monthly rewrites. Daily orders will be read at morning clinical meeting and orders will be written on current MAR and sent to pharmacy medical records for transcription. Monthly rewrite checks will be completed by 2 staff members with oversight of DNS/Designee for corrections. CD will monitor MARS daily for vitals/BP flow sheet in Mar is legible.</p> <p>2. To ensure compliance the DNS/Designee is responsible for completion of physician orders/rewrite audit tool, Lab audit tool, Mar/Tar documentation tool. The tools will be completed for 6 months with audits being completed weekly x 4 weeks, bimonthly x 2 months and monthly x 3 months. The results of these audits will be reviewed by the CQI committee monthly for 6 months after which the CQI team will re-evaluate the continued need for the audit. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>		

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	<p>She indicated, "We missed it [the metoprolol order] when we were checking orders."</p> <p>3. The clinical record of Resident #303 was reviewed on 11/4/15 at 11:30 a.m. Diagnoses for the resident included, but were not limited to, high blood pressure.</p> <p>A recapitulated physician's order for November, 2015, with an original order date of 6/17/15, indicated the facility was to check the resident's blood pressure twice a day.</p> <p>Review of the Medication Administration Record (MAR) for October, 2015, indicated illegible blood pressures at 9:00 a.m. on October 6, 8, 9, 10, 14, 15, 17, 18, 19, 20, 23, 25, 26, 27, 28, and 29, 2015, and at 5:00 p.m. on October 5, 6, 7, 8, 13, 14, 17, 18, 20, 23, 24, 25, 26, 27, and 31, 2015.</p> <p>Review of the MAR for September, 2015, indicated illegible blood pressures at 9:00 a.m. on September 4, 5, 10, 11, 15, 19, 20, 25, 29, 2015, and at 5:00 p.m. on September 5, 6, 9, 10, 12, 15, 22, 24, and 29, 2015.</p> <p>On 11/4/15 at 1:00 p.m., the Clinical Director reviewed the blood pressure documentation on the MARs for</p>			

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	September and October, 2015, and indicated, "I can't read some of them." She indicated the nurses needed more space on the MAR to document the blood pressures.				