

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 15, 16, 17, 18, 19, 22, 23, and 24, 2012</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Regina Sanders, RN-TC Shannon Pietraszewski, RN (October 15, 16, 17, 18, 19, 22, and 23, 1012) Jane Kaiser, RN (October 15, 16, 17, 18, 19, 22, and 23, 1012)</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 09 Medicaid: 36 Other: 10 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance.</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.</p>	

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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	Quality review completed on November 1, 2012 by Bev Faulkner, RN			

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F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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

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	<p>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> <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 observation and interview, the facility failed to revise informational signs for the Ombudsman, Executive Director, and Director of Nursing for 2 of 3 signs and failed to post telephone numbers and addresses to contact Medicare and Medicaid, which had the potential to affect 55 of 55 residents who reside in the facility.</p> <p>Findings include:</p> <p>1. During an observation on 10/16/12 at 8 a.m., a sign on the East Unit by the Nurses' Station had the incorrect name listed for the Ombudsman, Director of Nursing (DoN) and Executive Director.</p> <p>During an observation on 10/17/12 at 9 a.m., a sign on the East and West</p>	F0156	<p>F 156</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the incorrect signage.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Facility signage on both East and West Wings has been amended to reflect current facility personnel; Ombudsman and contact information for both Medicare and Medicaid Agencies.</p> <p>What measures will be put into</p>	11/23/2012

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	<p>Unit had the incorrect name listed for the Ombudsman, Director of Nursing (DoN) and Executive Director.</p> <p>During an observation on 10/18/12 at 4:12 p.m., a sign on the East and West Unit had the incorrect name listed for the Ombudsman, DoN and Executive Director.</p> <p>During an interview at the time of the observation, LPN # 11 indicated the signs had the wrong information listed. LPN #11 indicated the DoN listed had not worked at the facility since March.</p> <p>2. During the environmental tour with the Maintenance Director on 10/22/12 at 2:17 p.m., the telephone numbers and addresses to contact Medicare and Medicaid were not located.</p> <p>During an interview at the time of the observation, the Executive Director indicated the numbers were in a three ring binder in a bin in the front hallway. He indicated the numbers were not visible to residents and families.</p> <p>3.1-4(j)(3) 3.1-4(l)(1)</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility Receptionist to monitor posted signage and amend when necessary.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Executive Director to be responsible for insuring that the facility signage is current on a monthly basis and amended in the event of any personnel or Ombudsman changes. Documentation of this validation will be reflected on a monthly audit tool. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's physician of a medication error for 1 of 2 medication errors reviewed. (Resident #63)</p>	F0157	F 157 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A medication error form was completed to	11/23/2012	

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	<p>Findings include:</p> <p>Resident #63's record was reviewed on 10/22/12 at 8:20 am. The resident's diagnoses included, but were not limited to, arterial fibrillation and hypertension.</p> <p>The physician's recapitulation orders, dated 10/12, indicated an order originally dated 07/06/11 for digoxin (heart medication) 125 mcg (microgram), one tablet on Mondays, Wednesday, and Fridays.</p> <p>The resident's Medication Administration Record (MAR), dated 10/12, indicated the resident received the digoxin on 10/1 (Monday), 10/2 (Tuesday), 10/3 (Wednesday), 10/4 (Thursday), and 10/5 (Friday). The digoxin was then scheduled and given on Mondays, Wednesdays, and Fridays the rest of the month.</p> <p>The medical record lacked documentation to indicate a current digoxin level had been completed on the resident.</p> <p>During an interview on 10/22/12 at 9:48 a.m., the Nurse Consultant indicated the policy for medication errors is to notify the resident's</p>		<p>reflect the Digoxin administration error for Resident #63 and physician and family were notified. Physician declined need for a Digoxin level at this time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of residents requiring Digoxin administration has been completed to insure proper dosage and days of administration are being followed as ordered by the physician. No issues were identified via this audit. The need for corresponding lab work shall be discussed with each physician. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been educated on proper medication order transcription and adherence to special administration directives. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will audit 5 residents' medication administration records twice weekly until a threshold of 100% times 90 days for compliance; then once weekly until a threshold of 100% times 90 days for</p>		

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	<p>physician, fill out a medication error form, document on the medication error form and notification of the physician in the nurses notes. The Nurse Consultant indicated it looked like they started out giving the digoxin every day and then someone caught it.</p> <p>During an interview on 10/22/12 at 10:10 a.m., the Nurse Consultant indicated no medication error had been completed and the physician had not been notified.</p> <p>3.1-5(a)(2)</p>		<p>compliance and then once monthly until a threshold of 100% times 90 days for compliance to insure proper Digoxin administration as per the physician order. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F0166 SS=A	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to resolve a resident's grievance related to missing clothing for 1 of 3 residents reviewed for personal property. (Resident #80)</p> <p>Findings include:</p> <p>During an interview on 10/15/12 at 11:29 a.m., Resident #80 indicated she had sweats missing and they had been missing for a long time. Resident #80 indicated she had informed the staff, and laundry had been looking for the sweats.</p> <p>A concern form, dated 02/08/12, indicated the resident had a missing scoop neck sweater, gray sweats and a long sleeve black cardigan jacket. The form indicated the sweater and sweat pants were located. The form indicated on 02/09/12 the resident complained of a missing shirt. The resolution and disposition, signature of person following up and the Executive Director's signature was left blank on the form.</p>	F0166	<p>F 166</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A shirt was replaced and provided for Resident #80</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Administration reviewed grievance log for missing items since January 2012 and any missing items were replaced.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Department managers received inservice training related to policy for appropriate follow-up and resolution of resident/family grievances.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Executive Director to be responsible</p>	11/23/2012

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	<p>During an interview on 10/22/12 at 1:33 p.m., the Assistant Director of Nursing indicated nothing had been done about the missing shirt.</p> <p>An undated facility policy, received by the Director of Nursing on 10/19/12 at 2 p.m., titled, "Lost Property", indicated, "...3. Completed forms will be given to the social services department. The social services staff will facilitate a search of the item with the appropriate departments. 4. The designated staff member will complete an investigation and follow-up will be documented on the form. 5. After investigation and resolution, the completed form will be given to the executive director for a final review and signature...The social services staff will be responsible for communicating the resolution of the issue to the resident or responsible party. Notification of the resolution will be documented on the form...."</p> <p>3.1-7(a)(2)</p>		<p>for reviewing all grievances on a weekly basis to insure prompt and complete resolution to stated issues was achieved. Executive Director to initial grievance log when review is complete. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to schedule therapy around activities, failed to ensure the resident was up out of bed to attend morning activities, and failed to offer adaptive equipment due to the resident visual and hearing limitations. (Resident #59)</p> <p>Findings include:</p> <p>Resident #59 medical record was reviewed on 10/18/12 at 2:50 P.M. Diagnoses included but were not limited to macular degeneration disease, urosepsis, diabetes mellitus, leukocytosis, cerebrovascular disease, and congestive heart failure.</p> <p>A cognitive loss careplan, dated 9/13/12, indicated the resident had impaired cognitive skills.</p> <p>Interventions indicated for staff to ... invite, encourage, remind and escort to activity programs consistent with resident's interests...</p>	F0248	<p>F 248</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #59 required a new activity assessment to be completed secondary to a recent hospitalization and significant change in condition. Resident's care plan has been amended to reflect current activity preferences.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>The facility Activity Director completed a full facility audit of residents requiring and/or desiring one to one visits or individual activity preferences to ensure documentation is current and reflective of residents' needs and expressed interests.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the</p>	11/23/2012			

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	<p>A nursing assessment, dated 9/13/12, indicated the resident as being friendly and independent and social.</p> <p>An activities evaluation, dated 9/13/12, indicated Resident #59's current interest included animals/pets...cultural events, current events/news, education programs, family/friend visits, group discussions, movies, music, radio, reading, religious events/religious studies, sing a longs, socials/parties and television. There was no indication of type (individual, small or large group), no indication of importance to the resident, the resident's preference of location of activities, preferred wake up time in the morning and preferred time for naps.</p> <p>A MDS (Minimum Data Set Assessment) activity progress note, dated 9/13/12 to 9/20/12, indicated the resident would receive 1:1 visits as he would not participate in organized groups due to confusion and combativeness...per resident's daughter, the resident had macular degeneration disease (loss of vision). The "Independent activity involvement" section indicated the resident will converse with others. There was "N/A" (not applicable) in</p>		<p>deficient practice does not recur: Activity staff to conduct random interviews with residents to insure activity preferences and areas of interest are being addressed when possible. During monthly resident council meeting, facility representative to query the group for any suggested activity programs or outings that they wish to participate in.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Results of resident interviews and monthly meeting discussions/meeting minutes will be reviewed in the monthly Quality Assurance Meeting. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>the "sensory stimulation or other small group" section. The "Progress toward care plans" indicated the resident...needs encouragement, transports, and place for best hearing and resident will receive 1:1 visits."</p> <p>An activities careplan, dated 9/17/12, indicated Resident #59 "displayed confusion and was combative at times. Needs invite, transports to and from groups of choice." Interventions indicated to "...post activity calendar, invite, transport to activities as available, ... invite to discussion groups, ...entertainments..."</p> <p>An Admissions MDS assessment, dated 9/20/12, indicated it was somewhat important for the resident to keep up with the news, to do favorite activities, and to go outside when the weather was warm.</p> <p>A Care Plan Conference Record, dated 9/24/12, indicated Activities had documented the resident sleeps a lot and was not social.</p> <p>On 10/15/12 at 2:45 P.M., Resident # 59 was observed lying in bed asleep and did not participate in the afternoon activities of Bible and hymn that was taking place during this time.</p>			

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	<p>On 10/16/12 at 8:50 A.M., daily current events/newspaper was being read by activities in the front lobby. The resident was observed lying in bed during this time.</p> <p>On 10/17/12 at 9:15 A.M., daily current events/newspaper was being read by activities in the front lobby. The resident was observed lying in bed during this time.</p> <p>On 10/17/12 at 10:00 A.M., the resident was observed with therapy. The resident did not participate in the morning activities of exercise class during this time.</p> <p>On 10/17/12 at 2:00 P.M., the resident was observed with therapy. The resident did not participate in the morning activities during this time.</p> <p>On 10/18/12 at 9:15 A.M., daily current events/newspaper was being read by activities in the front lobby. The resident was observed lying in bed during this time.</p> <p>On 10/18/12 at 10:00 A.M., resident was observed with therapy. The resident did not participate in the morning activities of exercise during this time.</p>			

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	<p>On 10/22/12 at 3:15 P.M., the resident was observed being brought back from therapy and placed in the west dining room to watch TV.</p> <p>An interview with the Social Service Director on 10/22/12 at 3:20 P.M., indicated a referral for a psychiatric evaluation had been placed. The Social Service Director indicated the resident had been having some behavior issues.</p> <p>There was no documentation to indicate 1:1 activities were done after the activity assessment.</p> <p>Activities was not revised and individualized to meet the resident's needs due to macular degeneration disease, behaviors, and therapy. There was no indication for the resident to have had other adaptive equipment such as magnifying glass, communication devices, large print or talking books, hearings or newspapers on the 9/13/12 activities evaluation.</p> <p>3.1-33(a) 3.1-33(d)(2) 3.1-33(d)(3)</p>				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure Social Services was notified for assistance with planning care related to refusals of care and behaviors for 3 of 5 residents reviewed for Social Service. (Residents #39, #54, and #101)</p> <p>Findings include:</p> <p>1. Resident #39's record was reviewed on 10//23/12 at 9:51 a.m. The resident's diagnoses included, but were not limited to, dementia with associated behavioral symptoms and anxiety.</p> <p>A care plan 07/11/12, indicated the resident had dementia with agitation and had a history of yelling out and was disruptive to others. The approaches included, administer medications as ordered, offer snacks, toileting repositioning, activities. and one on one visits, rule out medical conditions/pain, redirect to activity: tv/music, notify the resident's family of any changes and encourage them to</p>	F0250	<p>F 250 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Social Services updated the care plan documentation for residents: 39;54;101 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of resident care plans was completed by the Social Service Director to insure documentation for residents requiring psychotropic medications; refusals of care and/or residents exhibiting behaviors is reflective of the residents' current plan of care. Necessary revisions were completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Social Service Director received education by the Social Service Consultant and Nursing Consultant regarding her role and involvement with regard to residents exhibiting behaviors and/or refusals of care. How the</p>	11/23/2012	

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	<p>visit, notify the physician of any concerns, refer to Psychology as ordered and on 09/05/12 medication change was added.</p> <p>A physician order, dated 8/8/12, indicated an order to increase the resident's Xanax (anti-anxiety medication) from 0.5 milligrams twice a day to three times a day.</p> <p>A physician's order on 09/05/12 indicated to increase the Xanax to four times a day.</p> <p>A Hospice note, dated 09/05/12, indicated the resident had increased feelings of being fearful and/or scared and the physician had been notified and the resident's Xanax had been increased.</p> <p>The resident's record indicated a lack of documentation to indicate Social Service had been made aware of the resident's feelings of fearfulness and the increase of the Xanax.</p> <p>The resident's care plan indicated a lack of documentation of a problem the resident was fearful and/or scared.</p> <p>During an interview on 10/23/12 at 11:30 a.m., the Social Service</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing administration to review/audit documentation by Social Service related to behaviors and refusals of care for those residents identified in the daily clinical meeting three times per week until a threshold of 100% times 90 days for compliance has been met; then once per week until a threshold of 100% times 90 days for compliance has been met. Any identified issues will be addressed immediately. Results of these audits will be reviewed in the Quality Assurance Meeting monthly. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>Director indicated she had not been aware the Xanax had been increased due to fear. She indicated she could not recall being told. She indicated they discuss increase in medications in the morning meetings and she had just started at the facility in June and was now monitoring the medications more closely.</p> <p>2. Resident #101's record was reviewed on 10/22/12 at 11:09 am. The resident's diagnoses included, but were not limited to, metastatic cancer and stage four (full thickness tissue loss) pressure ulcer to the coccyx.</p> <p>An Admission Minimum Data Set Assessment, dated 09/20/12, indicated the resident's cognition was intact and the resident was moderately depressed.</p> <p>A care plan, dated 09/20/12, indicated the resident was admitted with a stage four pressure ulcer. The approaches included, "...Staff to assist with positioning on routine rounds...Treatment as ordered..."</p> <p>The resident's care plan, dated 09/20/12, lacked documentation to indicate the resident was depressed and lacked documentation of Social</p>			

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	<p>Service involvement with the resident's care.</p> <p>The physician's recapitulation orders, dated 10/12, included an order, dated 09/14/12, for Physical Therapy to perform the resident's treatment on the stage four area three times a week and for nursing to complete the treatment on the other four days.</p> <p>The Treatment Administration Record (TAR), dated 10/12, indicated the resident refused the treatment to the stage four area on October 2, 3, 4, 9,10,11,13,14,16,17,18,19,20, and 21, 2012</p> <p>There was a lack of documentation on the TAR and the Nurses' Notes to indicate the reason for the refusal of the treatment.</p> <p>A Social Service note, dated 10/08/12 at 2:34 p.m., indicated the Social Service Director had a discussion with the resident's husband about the resident's prognosis and status, including the resident's refusal of treatments to the pressure area.</p> <p>The resident's care plan, dated 09/20/12, lacked documentation to indicate the resident was depressed</p>			

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	<p>and lacked documentation of Social Service involvement with the resident's care and the refusals of treatments for the pressure area.</p> <p>The Social Service progress notes lacked documentation the Social Service Director had spoken with the resident about her refusals of treatment and other psychosocial concerns.</p> <p>During an interview on 10/16/12 at 9:24 a.m., the Director of Nursing indicated the resident doesn't get out of bed, and doesn't come out of the room. She indicated the resident was very depressed and psychological services have been offered, but the resident has refused to be seen by the psychologist.</p> <p>3. Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip. The resident was admitted to the facility on 09/12/12.</p> <p>Resident #54's physician's recapitulation orders, indicated an order originally ordered on 09/12/12, for lorazepam (anti-anxiety) 0.5 milligrams every six hours as needed</p>			

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	<p>for anxiety.</p> <p>The MAR, dated 09/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>09/15 at 10 a.m. 09/16 at 10 a.m. 09/17 at 10 a.m. 09/18 at 10 a.m. and 10 p.m. 09/19 at 8 a.m. and 9 p.m. 09/22 at 3 a.m. and 4 p.m. 09/23 at 8 a.m. 09/25 at 1 a.m.</p> <p>The back of MAR indicated the resident received the lorazepam on September 17 (sic) at 8 a.m., 17 at 10 a.m., 19 at 8 a.m. and 9 p.m., 22 at 9:30 a.m. and 23 at 8 a.m. for complaints of anxiety.</p> <p>The MAR, dated 10/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>10/06 at 8:30 a.m. and 8:30 p.m. 10/15 at 2 p.m. 10/17 at 5 p.m. 10/18 at 5 p.m.</p> <p>The back of the MAR indicated the resident received the lorazepam on</p>						

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	<p>October 6 at 8:30 a.m. and 8:30 p.m., and 15, 2012 for yelling out.</p> <p>The progress notes indicated:</p> <p>Nurses' Note, 09/22/12 at 10:36 p.m., indicated the resident was yelling from her room she wanted to go home and requested the as needed pain medication.</p> <p>Social Service note, dated 09/24/12 at 9:55 a.m., indicated the resident was cursing and disrobing.</p> <p>Nurses' Note, dated 10/01/12 at 9:45 a.m., indicated the resident yells out at times.</p> <p>The resident's care plan, dated 09/20/12, indicated the resident was on psychotropic medications (anti-anxiety) and was at a risk for adverse reactions to the medication. The approaches included to give the medication as ordered and observe for signs and symptoms of adverse reactions.</p> <p>The care plan lacked documentation of the resident's behaviors and reason for the use of the lorazepam.</p> <p>The resident's record lacked documentation of Social Service</p>			

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	<p>interventions to the resident's behavior.</p> <p>During an interview on 10/18/12 at 3:45 p.m., CNA #12 indicated the resident had occasional behaviors, usually at night. She indicated the resident gets agitated and yells and curses. She indicated the resident is alright as long as someone is in the room, but the yelling starts up when the staff leave the room.</p> <p>During an interview on 10/19/12 at 8:55 a.m., the Social Service Director indicated the resident did not have a care plan for her behaviors. She indicated there was no Social Service documentation of resident's continued behaviors. She indicated she had not been addressing the problem. She indicated she should have been aware the resident had been receiving the lorazepam for anxiety. She indicated she could not recall being informed about the lorazepam. She indicated, "I have slept since then".</p> <p>3.1-34(a)</p>				

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F0272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS 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 resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure assessments were completed timely and accurately for the Minimum Data</p>	F0272	<p>F 272</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p>	11/23/2012

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	<p>Set (MDS) Assessments, related to urinary incontinency, side rail usage, medications, and cardiac status for 5 of 37 residents reviewed for assessments (Residents #5, #38, #40, #51, and #76)</p> <p>Findings include:</p> <p>1. Resident #38's record was reviewed on 10/23/12 at 8:45 a.m. The resident's diagnoses included, but were not limited to, cardiac dysrhythmia and post angiography. The resident was admitted from the hospital on 05/10/12 and returned to the hospital on 05/31/12 for a placement of a pacemaker.</p> <p>The Nursing Admission assessment, dated 05/10/12, indicated the resident had a pressure dressing to the right groin area from an "angio procedure."</p> <p>There was a lack of documentation to indicate what the area looked like under the dressing.</p> <p>The resident's Nurses' Notes, dated 05/11/12 through 5/16/12, indicated the resident's pulse had been obtained, but lacked documentation of an assessment of the resident's pulse (regular/irregular).</p>		<p>Note: Per review of documentation stated for Resident #5 (Side rail assessment and quarterly MDS) it was determined that these assessments were completed for Resident #57. Thus necessary revisions were made for this resident.</p> <p>Resident #57: A new side rail assessment was completed on 10-19-12.</p> <p>Resident #38: No longer resides in this facility.</p> <p>Resident #40's: Care plan has been updated to reflect Anti-coagulant and Antidepressant medication use.</p> <p>Resident #51: Urinary diary and urinary incontinence assessment completed. Care Plan was updated on 10-23-12 to reflect incontinence. Care Directive has been revised for incontinence.</p> <p>Resident #76 Physician orders, care plan and MDS have been amended to reflect pacemaker</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>Full facility audit of residents' medical data was completed to ensure that any resident that requires use of a pacemaker does have physician orders for maintenance and both the care plan and MDS reflect this need.</p>				

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	<p>The Admission/5 day MDS Assessment, with an observation end date of 5/16/12, indicated the resident had no surgical wounds and no dysrhythmias.</p> <p>2. Resident #5's record was reviewed on 10/18/12 at 8:23 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and hypertension.</p> <p>The Evaluation for Use of Side Rails assessment, dated 07/08/12, was left blank for the the following areas: Why is the use of the side rail(s) being considered? Identify all that contribute to the resident's need to use side rail(s): Will the side rail(s) assist the resident in: bed mobility, transfers, other Additional considerations: restraints, continence, toileting, medications, cognitive status. The Quarterly MDS Assessment, dated 07/19/12, indicated the resident did not use side rails as a restraint.</p> <p>During an interview on 10/19/12 at 3:13 p.m., the Director of Nursing indicated the side rail assessment had not been totally completed.</p>		<p>Audit of all residents requiring Anti-coagulant therapy was completed by Nursing Administration to insure use of the medication is reflected on the residents' plan of care. Audit of residents' with a diagnosis of Depression was also completed to insure the diagnosis is accurately reflected on the care and MDS.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff inserviced regarding the importance of reviewing medical data in order to validate whether a resident has a pacemaker and insuring follow-up maintenance orders are received and reflected on the physician order sheet.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to complete a chart audit on all new admissions to identify whether a resident has a pacemaker and to insure that maintenance orders for the pacemaker are received per the physician. Chart audits will be ongoing as per facility policy for all new admissions/readmissions. Audit results and system components will be reviewed by the QA Committee monthly with</p>				

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	<p>3. Resident #76's clinical record was reviewed on 10/18/12 at 8:30 A.M. Resident #76" diagnoses included but were not limited to, history of terminal heart disease (Elsenmengers Syndrome), history of sick sinus syndrome (heart condition), cardiomegaly, severe pulmonary hypertension, and chronic encephalopathy.</p> <p>A cardiology consultation report, dated May 21, 2011, indicated the resident having a pacemaker placed in 2008.</p> <p>A (Preadmission Screening Resident Review) PASRR, dated 6/8/11, did not indicate the resident as having a pacemaker.</p> <p>The Admission Nursing Assessment, dated 6/15/11, did not indicate the resident as having a pacemaker.</p> <p>Admission MDS (Minimum Data Set Assessment), dated 6/18/11, the quarterly MDS, dated 4/30/12 and the annual MDS, dated 7/20/12, did not indicate the resident as having a</p>		subsequent plans of correction developed and implemented as deemed necessary.		

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	<p>pacemaker.</p> <p>A radiology report on 9/29/11 indicated the resident as having a pacemaker.</p> <p>A radiology report on 10/16/12 indicated the resident as having a pacemaker.</p> <p>Interview with the MDS Coordinator, LPN #7 and #9 on 10/19/12 at 2:45 P.M. indicated they were not aware of the resident having a pacemaker.</p> <p>Interviewed the DON (Director of Nursing) on 10/19/12 at 3:15 P.M. The DON indicated she was not aware of the resident having a pacemaker.</p> <p>The pacemaker was not identified on admission and thereafter.</p> <p>4. Resident #40's clinical record was reviewed on 10/19/12 at 9:00 A.M. Resident #40's diagnoses included but were not limited to, CHF (congestive heart failure), history of diabetes mellitus, history of myasthenia gravis, gastrointestinal bleed, dementia, chronic atrial fibrillation, history of chronic deep vein thrombosis (blood clot).</p>			

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	<p>On 7/9/12, an order for Zoloft (antidepressant) 25 mg (milligrams) was initiated.</p> <p>On 8/9/12, Xarelto (blood thinner) 15 mg was initiated during the resident's hospitalization. Aspirin 81 mg continued daily as a prophylaxis.</p> <p>A Nursing Note dated 8/13/12 at 5:42 P.M., indicated the resident was readmitted to the facility on 8/11/12 with multiple purple bruises (Left 3rd knuckle 1.5 cm (centimeters) x 1.5 cm, left forearm 1.5 cm x 2 cm, left inner forearm 1.5 cm x 1.5 cm and 2.5 cm x 2 cm, left posterior forearm 1.5 cm x 1.5 cm, left upper arm 1 cm x 1 cm, right upper arm 2 cm x 2 cm, right 2nd finger 1 cm x 1 cm, right 3rd finger 3 cm x 1.5 cm).</p> <p>A nursing note, dated 8/26/12 at 2:40 P.M., indicated the resident was scratching his arm and developed a reddish and purple area on the upper arm measuring 9.0 cm x 6.0 cm and the lower arm site measuring 10 cm x 8.0 cm.</p> <p>A nursing note, dated 8/27/12 at 4:07 P.M., indicated the resident had bruises to the left arm. A large deep purple bruise to left upper arm measured 8 cm x 7 cm and was</p>						

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	<p>slightly raised and the left elbow had a deep purplish/red area measuring 5 cm x 6 cm .</p> <p>A nursing note, dated 10/13/12 at 6:41 P.M., indicated the resident had a small amount of bleeding when he ate.</p> <p>A nursing note, dated 10/15/12 at 6:22 P.M., indicated the resident had drainage pink in color due to the sutures bothering the resident. Also a discoloration was observed to right side of his mouth.</p> <p>A nursing note, dated 10/17/12 at 4:29 P.M., indicated the resident had a bruise "still" to right side of his face near his mouth from recent removal of teeth.</p> <p>An interview with the Social Service Director on 10/19/12 at 2:15 P.M., indicated she was "just looking at behaviors from last month to this month and was carrying over and assessing her findings" when asked if she was aware of the resident's diagnosis for depression.</p> <p>An interview with LPN #7 and #9 on 10/19/12 at 2:45 P.M. indicated they did not know what Xarelto was. LPN #7 indicated the oral surgeon gets a</p>						

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	<p>copy of the medication sheet with visits.</p> <p>An interview with the DON (Director of Nursing) at 3:15 P.M. indicated she did not know Xarelto was.</p> <p>The quarterly MDS assessment, dated 6/18/12 and 9/13/12, did not indicate the resident as being on a blood thinner or having a diagnoses for depression.</p> <p>5. A record review on 10/23/12 at 3 p.m., indicated Resident #51 had diagnoses including, but not limited to: Diabetes Mellitus, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hyperlipidemia, Depression and Dementia. The record indicated the resident had been admitted into the facility on 06/04/12</p> <p>The "URINARY STATUS INTERVIEW --To be completed by nurse on admission (06/04/12) with input from the resident and/or family." indicated the resident was incontinent of bowel and bladder occasionally, had occasional urine leakage, was never treated for leakage, and used briefs and more frequent use of the restroom to help alleviate the</p>			

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	<p>problem. The form was not signed by the assessor</p> <p>An Admission/5 day Minimum Data Set (MDS) Assessment, dated 6/11/12 indicated Resident #51's cognitive status was severely impaired (score of 6), one person physical assistance required for transfers and Activities of Daily Living(ADL) and use of wheelchair. The resident was not on any urinary toileting program. He was occasionally incontinent of urine (less than 7 episodes per week), but always continent of bowels.</p> <p>The "ASSESSMENT FOR BOWEL AND BLADDER TRAINING" completed for Resident #51 on 6/14/12 indicated a score of 12, which indicated he was a "candidate for toileting, timed or scheduled voiding."</p> <p>An undated "URINARY INCONTINENCE ASSESSMENT" indicated the resident was incontinent of urine.</p> <p>The quarterly MDS Assessment on 8/31/12 indicated a decline in Resident # 51's cognitive status and was severely impaired (score of 2). He required 1 person physical assistance for transfers and ADL's</p>			

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	<p>and used a wheelchair. There was a decline in the resident's incontinence to frequently (7 or more episodes of incontinence per week, but 1 episode of continence) and was not on any urinary toileting program.</p> <p>The CNA's information sheet, received from the Director of Nursing as current on 10/23/12 at 3 p.m., indicated the resident was continent.</p> <p>The Monthly Flow Reports, dated 06/12, 08/12, and 10/12, received from the MDS Coordinator on 10/22/12 at 12:36 p.m., indicated the resident had 7 incontinent episodes in June, 71 incontinent episodes in August and 121 incontinent episodes on October.</p> <p>During an interview with the MDS Coordinator on 10/23/12 at 3:34 p.m., she acknowledged the resident has declined and the resident had not been started on a personalized toileting program. She indicated the resident should have been reassessed in August.</p> <p>During and interview on 10/23/12 at 3:51 p.m., CNA #6 indicated Resident #51 was always incontinent for her on the 3 to 11 p.m. shift, wore a brief and</p>			

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	<p>didn't communicate when he had to urinate or defecate. He would get up for dinner and was able to help transfer, but does not do anything else. She would toilet him before and after dinner and sometimes he would urinate, sometimes not. She indicated he was mostly incontinent.</p> <p>3.1-31(a)</p>			

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop care plans related to daily preferences, hospice, medications, pressure ulcers, weight loss, and vision for 7 of 37 residents reviewed for care plans. (Residents #33, #45, #53, #54, #56, #59, and #105)</p> <p>Findings include:</p> <p>1. Resident #53's clinical record was reviewed on 10/22/12 at 9:14 A.M. Resident #53's diagnoses included but were not limited to dementia,</p>	F0279	<p>F 279 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Physician and family have been notified of 12% weight loss in 30 days for Resident #54 Resident #56: Care plan was updated to reflect non-compliance with repositioning in bed Resident #53: Care plan amended to reflect resident's preference for sleeping in and staying up late Resident #45: Care plan now reflects "end of life" care measures including signs/symptoms of physical and mental decline in addition to off</p>	11/23/2012

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	<p>diabetes mellitus, congestive heart failure, shortness of breath and chronic obstructive pulmonary disease.</p> <p>An Activity Progress note, dated 3/17/12 to 3/23/12, indicated it wasn't very important for the resident to choose her bedtime. The note also indicated the resident ate most meals in the main dining room, she reads and watches TV daily.</p> <p>A quarterly dietary note on 9/10/12 indicated the resident eats all meals in the main dining room.</p> <p>On 10/15/12 at 9:14 A.M., observed Resident #53 to be in bed.</p> <p>On 10/15/12 at 10:30 A.M., observed the resident to be in bed asleep.</p> <p>On 10/15/12 at 11:45 A.M., observed the resident to be in bed. During this time, the resident was interviewed and she indicated she did not sleep well and was very sleepy.</p> <p>On 10/15/12 at 3:15 P.M., observed the resident to be in bed asleep.</p> <p>On 10/16/12 at 8:45 A.M., observed the resident to be in bed asleep.</p>		<p>loading the heels while in bed. Resident #33: Care plan has been amended to include need for Anti-coagulant therapy Resident #105: Care plan now reflects need for psychoactive medication use and diagnosis of Parkinson's Disease. Resident #59: Care plan now reflects the resident's Macular Degeneration Disease and Anti-coagulant therapy has been discontinued. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility care plan audit was completed by Nursing Administration to validate that pertinent resident care information is reflected on the plan of care. Necessary revisions were completed as indicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses were inserviced on the importance of insuring that all new or discontinued physician orders are reflected on the resident's care plan at the time the order is received. This practice will insure that the plan of care is current for the resident. How the corrective action(s) will be monitored to ensure the</p>		

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	<p>On 10/19/12 at 8:30 A.M., observed the resident to be in bed asleep.</p> <p>On 10/22/12 at 8: 35 A.M., observed the resident to be in bed asleep.</p> <p>Interview with CNA #6 on 10/22/12 at 1:40 P.M., indicated the resident didn't want to get up because she was sleepy.</p> <p>Interview with LPN #5 on 10/23/12 at 8:30 A.M., indicated the resident stays up most of the night and likes to sleep in the mornings. She also indicated the resident is not a breakfast person and will get up for lunch.</p> <p>There were no care plan's regarding the resident's daily preference of sleeping in/staying up late.</p> <p>2. Resident #45's clinical record was reviewed on 10/19/12 at 10:15 A.M. Resident #45's diagnoses included but were not limited to old cerebral vascular accident (stroke), chronic kidney disease, diabetes mellitus, and septic syndrome.</p> <p>October 2012 Physician Recapitulation orders indicated on 5/30/12, the resident was admitted to hospice and the resident was on</p>		<p>deficient practice will not recur: Nursing Administration will audit 5 resident care plans twice weekly until a threshold of 100% times 90 days for compliance has been met; then once weekly until a threshold of 100% times 90 days for compliance and then once monthly until a threshold of 100% times 90 days for compliance to insure that the care plan addresses the resident's current care related needs. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>oxygen at 2L (liters) per N/C (nasal cannula).</p> <p>An interview with the Social Service Director on 10/19/12 at 2:00 P.M., indicated she was newly hired in June and she was trying to go through all the residents' records to see who needed a care plan. She also indicated there was a lapse of time from social worker to social worker and the designee social worker did the best she could.</p> <p>There was no care plan indicating care/comfort measures for end of life, including signs and symptoms of physical/mental decline.</p> <p>3. Resident #33's clinical record was reviewed on 10/18/12 at 9:00 A.M. Resident's #33's diagnoses included but were not limited to deep vein thrombosis (blood clot), congestive heart failure, dementia, and Alzheimer's disease.</p> <p>A nursing note, dated 7/18/12 at 11:58 A.M., indicated the resident was receiving 5mg of Coumadin and was increased to 7.5 mg.</p> <p>A nursing note, dated 7/21/12 at 9:34 P.M., indicated the resident was found to have a bruise on her right</p>			

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	<p>knee. An investigation report indicated the resident to be on Coumadin.</p> <p>October 2012 Physician Recapitulation orders indicated the resident was receiving Coumadin (blood thinner) daily.</p> <p>An interview with LPN #7 on 10/22/12 at 11:30 A.M. indicated floor nurses are able to initiate care plans.</p> <p>Review of the care plans indicated a care plan related to the use of Coumadin had not been developed.</p> <p>4. Resident #105's clinical record was reviewed on 10/17/12 at 1:20 P.M.</p> <p>A dictated neurology visit report for 10/9/12 indicated the resident to be on Risperdal at bedtime on 10/1/12.</p> <p>A physician exam note for 10/11/12 indicated Resident #105 to have severe Parkinson's disease with dementia. Resident #105 also had increased rigidity. Klonopin was used for symptom management of Parkinson's disease.</p> <p>A social service note, dated 10/12/12 at 2:57 P.M., indicated the Risperdal</p>			

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	<p>was ordered by a neurologist and was prescribed for hallucinations.</p> <p>An interview on 10/19/12 at 2:00 P.M., with the Social Service Director indicated she had just went through his information and was working on his careplan.</p> <p>There was no care plan for the psychoactive medications or a care plan for the Parkinson's disease.</p> <p>5. Resident #59 clinical record was reviewed on 10/18/12 at 2:50 P.M. Resident's #59 diagnosis included but were not limited to macular degeneration disease, urosepsis, diabetes mellitus, leukocytosis, cerebrovascular disease, and congestive heart failure.</p> <p>The 9/13/12 Admission Assessment indicated the resident wore glasses and had macular degeneration.</p> <p>The MDS 3.0 Activity Progress note dated 9/13/12 to 9/20/12 indicated the resident as having macular degeneration and was not able to read print easily.</p> <p>The Physician Recapitulation orders for October 2012 indicated the resident was receiving Aggrenox</p>			

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	<p>(blood thinner/prevent clotting) twice a day for cerebrovascular disease.</p> <p>Interview with LPN #7 on 10/22/12 at 11:30 A.M., indicated floor nurses are able to initiate care plans.</p> <p>There was no care plan regarding the macular degeneration disease or the use Aggrenox (platelet inhibitor/blood thinner).</p> <p>6. Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip. The resident was admitted to the facility on 09/12/12.</p> <p>The Nurses Admission assessment, dated 09/12/12, indicated the resident's weight was 190.8 and no edema was present.</p> <p>The Nutrition Intervention Program (NIP) notes, indicated the resident's weight on 09/24/12 was 182.4 and 10/01/12 the resident's weight was 178.7 (decrease of 12% in 30 days).</p> <p>The NIP notes on 09/17/12 indicated, "...edema BLE (bilateral lower extremities)...."</p>			

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	<p>The NIP notes, dated 09/24/12, indicated, "...wt (weight) decrease (arrow down) may be 2o (secondary to) decrease (arrow down) edema..."</p> <p>The resident's physician's orders, dated 09/25/12, indicated an order to hold the resident's Diovan (anti-hypertensive) 160 milligrams daily and the Lasix (diuretic) 20 milligrams twice a day.</p> <p>A physician's order, dated 10/03/12, indicated to continue to hold the Diovan and the Lasix.</p> <p>The Medication Administration Record (MAR), dated 09/12, indicated the medications were not given 09/26/12 through 09/30/12.</p> <p>The MAR, dated 10/12, indicated the medications were not given 10/01/12 through 10/18/12.</p> <p>The Nurses' Notes, dated 09/13/12 at 7 a.m., 09/14/12 at 6:50 a.m., 09/25/12 at 3:36 p.m., 09/26/12 at 8:21 p.m., 09/29/12 at 10:46 a.m., and 10/13/12 at 4:31 a.m., indicated the resident had no edema. There was a lack of documentation to indicate if the resident had edema in the other Nurses' Notes from</p>			

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	<p>admission to 10/12/12.</p> <p>There was a lack of documentation to indicate the resident had a care plan related to the significant weight loss.</p> <p>During an interview on 10/19/12 at 9:30 a.m., the Dietary Manager (DM) indicated a weight loss care plan had not been completed yet. She indicated she had not received the weight losses from the Registered Dietician (RD) yet. She indicated she was not aware the resident had lost weight.</p> <p>During an interview on 10/19/12 at 2:14 p.m., the RD indicated that on 09/24/12 she did a nutrition assessment and crossed out no edema and put there was edema. She indicated on the 9/17/12 NIP notes it was documented the resident had bilateral lower extremity edema. She indicated the resident had lost 12% since admission, but 10/04/12 was not 30 days after admission and the care plan for the weight loss would have been written this week. (weight loss occurred on 10/01/12)</p> <p>7. Resident #56's record was reviewed on 10/18/12 at 10:11 a.m.. The resident's diagnoses included, but were not limited to, Stage IV</p>			

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	<p>sacral decubitus (full loss of skin tissue) and paraplegia related to spinal cord tumor.</p> <p>The Quarterly MDS Assessment, dated 08/17/12, indicated the resident's cognition was intact and required extensive assistance with bed mobility.</p> <p>A care plan, dated 06/17/12, indicated the resident had a Stage IV pressure ulcer. The approaches included to minimize pressure over bony prominences and to turn and reposition the resident every two hours and as needed with routine care.</p> <p>During an interview on 10/18/12 at 10:30 a.m., CNA #14 indicated the resident tells us where to put pillows when we position her. She indicated the staff would like to do more for the resident (positioning), but the resident doesn't want us to. CNA #14 indicated she rolls herself in bed and then the staff positions the resident off her back with pillows. CNA #14 indicated the resident is non-compliant with repositioning. CNA #14 indicated they tell the nurse when the resident refused to turn.</p>			

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	<p>During an interview with LPN #11 on 10/18/12 at 10:30 a.m., she indicated the resident does not like to be turned. LPN #11 indicated the CNA's will tell me if the resident refused to turn. LPN #11 indicated non-compliance should be care planned for the resident. LPN #11 indicated there was no care plan for the non-compliance for turning.</p> <p>3.1-35(a)</p>			

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F0280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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 record review and interview, the facility failed to revise or update care plans related to vision and pressure areas (Residents #45 and #54) and failed to invite the resident and/or family members to participate in care plans (Residents #45, #57, #63, and #71) for 5 of 37 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. Resident #63's record was reviewed on 10/22/12 at 8:20 am. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p>	F0280	<p>F 280 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #54; Care plan was reviewed by the interdisciplinary team on 11/01/12. Care plan has been amended to reflect positioning of heels while in bed. .Resident #63: Care plan was reviewed by the interdisciplinary team on 11/05/12. Family (POA) attended the conference although the resident declined the invitation. Resident #71: Care plan was reviewed by the interdisciplinary team on 10/31/12. Both resident and family were in attendance and questions/concerns were</p>	11/23/2012	

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	<p>The Care Plan Conference Record in the clinical record, indicated the last date the resident had a care plan conference with/or without the resident and responsible party/family was 10/26/11.</p> <p>During an interview on 10/22/12 at 8:45 a.m., the Housekeeping Supervisor, indicated she scheduled the care plan conferences prior to the Social Service Director starting in June. She indicated she had left a message for the family in March of 2012 to set up a care plan conference, but there was nothing to confirm that this was completed. She acknowledged there had been no other care plan conference since 10/26/11.</p> <p>2. During a family interview on 10/16/12 at 3:41 p.m., Resident #71's family indicated they had not been invited to a care plan conference in a long time.</p> <p>Resident #71's record was reviewed on 10/18/12 at 9 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke.</p> <p>The Care Plan Conference Record in the clinical record, indicated the last</p>		<p>addressed. Resident #45: Care plan was reviewed with VNA and family member on 11/01/12. POA chose to represent the resident at the conference. Care plan has been amended to reflect positioning of heels while in bed. Resident #57: Care plan conference is scheduled for 11/20/12 per resident's choice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of resident care plans/care conference attendance records has been completed by the Social Service Director to validate that care conferences are scheduled accordingly with both the resident and family member. Invitations via letter format have been sent to family members of the residents scheduled for a care plan conference and updated conference schedules have been provided to the members of the interdisciplinary team. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Social Service Director has been re-educated on the procedure for scheduling care plan conferences and inviting all appropriate parties. Care plan conferences will be scheduled in accordance with</p>		

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	<p>date the resident had a care plan conference with/or without the resident and responsible party/family was 02/17/11.</p> <p>A Social Service Progress Note, dated 03/22/12, indicated the facility left a message with the resident's son to set up a care plan meeting. The notes lacked documentation of any further attempts to set up a care plan meeting.</p> <p>During an interview on 10/19/12 at 9:50 a.m., the Social Service Director (SSD) indicated she sends letters to the family and resident for a quarterly care plan review and then she documents on the Care Plan Conference Record. Further interview with the SSD at 9:55 a.m., indicated there had not been a letter sent out to the resident's family. The SSD indicated no care plan conference had been done since 02/17/11. She indicated care plan conferences should be done quarterly. She indicated she started the SSD position in June and she is now looking to see what residents' care plans need done.</p> <p>3. Resident #57's record was reviewed on 10/18/12 at 8:35 a.m. The resident's diagnoses included,</p>		<p>the quarterly MDS schedule, and as needed, based on resident need or change of condition. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Executive Director will be responsible to insure that the care plan conference schedule is in accordance with the MDS schedule and invitation letters are mailed in a timely manner. This audit will be completed on a monthly basis and verification will be documented on audit tool. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>but were not limited to, congestive heart failure and hypertension.</p> <p>The Care Plan Conference Record in the clinical record, indicated the last date the resident had a care plan conference with/or without the resident and responsible party/family was 6/06/11.</p> <p>During an interview on 10/22/12 at 8:45 a.m., the Housekeeping Supervisor, she indicated the resident was invited to the care plan conference on 4/30/12 and declined to come. She indicated there had not been another invitation to the care plan meeting since then.</p> <p>4. Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip.</p> <p>A care plan, dated 9/17/12, indicated the resident was a risk for pressure ulcers. The approaches included a pressure reducing mattress, preventative skin care, assist with positioning on routine rounds and as needed, and check skin during care and bathing.</p> <p>On 10/3/12 the care plan was revised</p>			

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	<p>to include a left heel blister and an approach for treatment change was added.</p> <p>During an interview 10/18/12 at 3:45 p.m., CNA #12 indicated she would elevate the resident's heels off the bed.</p> <p>During an interview on 10/18/12 at 9:33 a.m., the Minimum Data Set Nurse indicated the care plan had not been revised to include keeping the resident's heels off the bed. She indicated the nurses should have revised the care the care plan.</p> <p>6. Resident #45's clinical record was reviewed on 10/19/12 at 10:15 A.M. Resident #45's diagnoses included but were not limited to old cerebral vascular accident (stroke), chronic kidney disease, diabetes mellitus, and septic syndrome.</p> <p>There was no care plan conference found in electronic charting. The last care plan conference record found was 5/17/11. The care plans were all dated 8/28/12.</p> <p>A care plan, dated 8/28/12, indicated the resident was at risk for pressure ulcers. The interventions indicated to...weekly skin</p>						

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	<p>assessments...preventative skin care; pressure reducing mattress in use...</p> <p>An Initial Data Collection Tool/Nursing Service assessment, dated 5/24/12 at 2:00 P.M., indicated the resident had reddened bilateral heels. The resident had heel protectors on. Physical functioning for bed mobility indicated one to two person assist and total dependence.</p> <p>A care plan, dated 8/28/12, indicated the resident was at risk for pressure ulcers. Interventions included...preventative skin care, weekly skin checks by nurse, pressure reducing mattress...</p> <p>An interview with the resident's daughter on 10/16/12 at 12:41 P.M., indicated she had not been invited to the care plan meetings and the only conference she had attended was when the resident was readmitted to the facility in May, 2012.</p> <p>On 10/17/2012 at 9:07 A.M., the resident's right heel was observed touching the mattress while lying in bed.</p> <p>On 10/18/12 at 8:25 P.M., bilateral heels were observed touching the mattress while lying in bed.</p>			

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	<p>On 10/19/12 at 10:45 AM., the resident was observed in bed. Bilateral lower extremities was edematous and both heels were touching the mattress. Both legs were in a downward motion while elevation was observed at the knees.</p> <p>An interview with the Social Service Director on 10/19/12 at 2:00 P.M., indicated she started the position in June and she has been trying to go through all the residents to see who needs a careplan. There has been a lapse of time from social worker to social worker and the designee had been doing the best she could.</p> <p>On 10/19/12 at 3:00 P.M., bilateral heels were observed on the bed. An interview with the hospice nurse at this time indicated there has been no care plan meeting with the facility.</p> <p>An interview with the ADON (Assisted Director of Nursing) on 10/22/12 at 10:45 A.M., indicated if a resident was found to have reddened heels, the procedure would be to offload heels and careplan the findings. The ADON clarified the care plans being initiated on 8/28/12 and not earlier was because they were being entered into the computer on 8/28/12.</p>			

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	<p>On 10/22/12 at 1:45 P.M., the resident was observed to have bilateral heels on the mattress with elevation to the knees. Bilateral lower extremities was edematous. The resident bilateral heels was observed to be soft and mushy.</p> <p>There was no care plan revision regarding positioning of heels and no care plan meeting with family or with hospice since the resident was readmitted in May, 2012.</p> <p>3.1-35(c)(1) 3.1-35(d)(2)(B)</p>				

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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observations, record review, and interview, the facility failed to follow physician's orders and care plans related to falls, toileting programs, medications, blood sugars, geri-sleeves (skin protectors), and fluid intake and output for 6 of 37 residents reviewed for physician's orders and care plans. (Residents #26, #40, #54, #59, #63, and #80)</p> <p>Findings include:</p> <p>1. Resident #63's record was reviewed on 10/22/12 at 8:20 am. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p> <p>The physician's recapitulation orders, dated 10/12, included an order originally dated 07/06/11 for digoxin (heart medication) 125 mcg (microgram), one tablet on Mondays, Wednesday, and Fridays.</p> <p>The resident's Medication Administration Record (MAR), dated 10/12, indicated the resident received</p>	F0282	<p>F 282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #63: Physician declined need for Digoxin level and resident is receiving the medication as ordered. Resident #80: Medication error form was completed and both the physician and family were made aware of the omitted medication. Resident #54: Medication error form was completed related to sliding scale insulin administration. Resident #59: No longer requires application of geri sleeves Resident # 40: Fluid restriction has been discontinued for this resident. Resident # 26: No longer resides in this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:Full facility audit of medication administration records has been completed by Nursing Administration to verify that all medications are being</p>	11/23/2012	

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	<p>the digoxin on 10/1 (Monday), 10/2 (Tuesday), 10/3 (Wednesday), 10/4 (Thursday), and 10/5 (Friday). The digoxin was then scheduled and given on Mondays, Wednesdays, and Fridays the rest of the month.</p> <p>The medical record lacked documentation to indicate a current digoxin level had been completed on the resident.</p> <p>During an interview on 10/22/12 at 9:48 a.m., the Nurse Consultant indicated it looked like they started out giving the digoxin every day and then someone caught it.</p> <p>During an interview on 10/22/12 at 10:10 a.m., the Nurse Consultant indicated no medication error had been completed.</p> <p>2. Resident #80's record was reviewed on 10/19/12 at 1 p.m. The resident's diagnoses included, but were not limited to, bipolar disease and diabetes mellitus.</p> <p>A physician's order, dated 9/21/12, indicated to administer Xanax (anti-anxiety) one milligram for a one time dose for increased anxiety and Ativan (anti-anxiety) 0.5 milligram twice a day for three days for</p>		<p>administered in accordance with physician orders. Issues were identified and immediately addressed via this audit. Full facility audit of blood glucose records has been conducted by Nursing Administration to insure insulin has been administered as directed by physician. Issues were immediately addressed with involved staff and physician. Full facility audit of geri sleeves was completed by Nursing Administration to validate adherence to this intervention. Care directives were updated as necessary. Full facility audit of residents requiring fluid restriction was completed by Nursing Administration to ensure accurate and timely completion of the intake and output documentation to ensure residents receive adequate hydration within fluid restrictions What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been inserviced on the following topics by Nursing Administration: Transcription of physician orders; adherence to physician orders for medication administration; sliding scale insulin administration; geri sleeve application and insurance that preventative devices are in</p>		

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	<p>increased anxiety.</p> <p>A Nurses' Note, dated 09/21/12 at 2:16 p.m., indicated the resident's previous roommate had passed away and the resident had been very tearful and crying frequently and the physician had been notified and new orders had been obtained.</p> <p>The resident's MAR, dated 09/12, lacked documentation the resident received the Xanax and and the Ativan as ordered by the physician.</p> <p>During an interview on 10/19/12 at 1:32 p.m., LPN #11 indicate the medication was not marked as given per physician's orders on the MAR.</p> <p>3. Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip. The resident was admitted to the facility on 09/12/12.</p> <p>The physician's recapitulation orders, dated 10/12, indicated an order to check blood sugars four times daily with insulin coverage per the blood sugar result (sliding scale). The insulin order, originally dated 09/12/12, indicated Novolin</p>		<p>place as directed; intake/output monitoring; care plan revisions based on new and discontinued physician orders How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will audit 10 medication administration records twice weekly until a threshold of 100% times 90 days for compliance; then once weekly until a threshold of 100% times 90 days for compliance and then monthly until a threshold of 100% times 90 days for compliance to insure medications are being administered in accordance with the physician's directives. Nursing Administtion to audit 5 glucose monitoring records twice weekly until a threshold of 100% times 90 days for compliance; then once weekly until a threshold of 100% times 90 days for compliance and then monthly until a threshold of 100% times 90 days for compliance to ensure insulin is administered as directed via sliding scale. Nursing Administration will audit 10 physician orders twice weekly until a threshold of 100% times 90 days for compliance; then once weekly until a threshold of 100% times 90</p>				

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	<p>Regular-151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and over 401=12 units and call physician.</p> <p>A care plan, dated 09/20/12, indicated the resident was a risk for hyper (high) or hypoglycemia (low blood sugar). The approaches included to administer insulin as ordered and to perform Accuchecks (blood sugar checks) as ordered..."</p> <p>The sliding scale insulin form, dated 09/12, indicated the resident's blood sugar on 09/24/12 at 4 p.m. was 393 and 12 units of insulin was given (should have received 10 units). The form indicated the resident's blood sugar had not been obtained on 09/28/12 at 4 p.m. and 9 p.m.</p> <p>The sliding scale insulin form, dated 10/12, indicated the resident's blood sugar on 10/15/12 was 282 and 4 units of insulin given (should have been 6 units); the blood sugar on 10/16/12 at 4 p.m., was 300 and 8 units was given (should have been 6 units); and 10/16/12 at 9 p.m., the blood sugar was 221 and 2 units was given (should have been 4 units).</p> <p>During an interview on 10/19/12 at 8:50 a.m., LPN #11 indicated the</p>				<p>days for compliance and then monthly as per protocol of the clinical meeting held Monday through Friday to validate that proper order transcription and follow through to the care plan is completed by the licensed nurse. Nursing Administration to visually observe up to 5 residents and audit up to 5 treatment administration records weekly until a threshold of 100% times 90 days for compliance to validate placement of the geri sleeves as directed by the physician. Nursing Administration will be responsible to audit 5 intake/output records which include fluid restrictions weekly until a threshold of 100% times 90 days for compliance to insure timely and accurate documentation by all 3 shifts.</p> <p>Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>insulin dosages were incorrect.</p> <p>4. Resident #26's record was reviewed 10/22/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Failure to Thrive, Hypertension, HIV+, Hepatitis C, anxiety and depression.</p> <p>An Admission/5-Day Minimum Data Set (MDS) Assessment, dated 09/27/12, indicated Resident #26's cognitive status was severely impaired, required 2 person assistance for transfers and Activities of Daily Living (ADL) and use of wheelchair.</p> <p>A careplan written 9/27/12 indicated Resident #26 "is at risk for injuries from falls" and interventions include, but are not limited to: "...Low bed (9/29/12)... mat on floor (10/9/12)...15 min checks " (visualization of resident by staff)(10/12/12).</p> <p>A fall investigation, dated 10/9/12 at 7:10 a.m., with statement by LPN #5, indicated Resident #26 slid out of bed to the floor when trying to transfer to wheelchair, low bed was raised, mat folded by the wall. Resident indicated day CNA had just assisted her. Actions indicated were: staff education regarding safety and</p>			

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	<p>re-instruction and encourage resident to use call light for assistance.</p> <p>During observation on 10/22/12 at 8:55 a.m., Resident # 26 was in her room with the door shut (but not latched). There was no entry, visualization or interaction with any staff observed until 10:03 a.m., when Resident # 26 yelled out once. LPN # 9 immediately responded to the resident's call. The facility staff failed to check the resident every 15 minutes from 8:55 a.m. through 10:03 a.m. (1 hour and 8 minutes).</p> <p>5. Resident #59 clinical record was reviewed on 10/18/12 at 2:50 P.M. Resident's #59 diagnosis included but were not limited to macular degeneration disease, urosepsis, diabetes mellitus, leukocytosis, cerebrovascular disease, and congestive heart failure.</p> <p>On 9/13/12, an Admission Skin Assessment indicated a skin tear to left hand.</p> <p>A physician order on 10/10/12 indicated steri-strips to left and right hand skin tears.</p> <p>A Braden Skin Assessment, dated 10/10/12, indicated skin tears to bilateral hands.</p>			

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	<p>A careplan, dated 10/10/12, indicated the resident had a skin tear to right and left hand. The interventions indicated to hydrate skin, geri gloves, and treatment as ordered.</p> <p>On 10/15/12 at 2:45 P.M., Resident # 59 was observed with no geri gloves on.</p> <p>On 10/16/12 at 8:30 A.M., the resident was observed with no geri gloves on.</p> <p>The resident was observed on 10/22/12 at 3:00 P.M. to have steri-strips on the left hand and another area was scabbed. The geri glove was observed on the right hand, but not on the left.</p> <p>6. Resident #40's clinical record was reviewed on 10/17/12 at 1:55 P.M. Resident #40's diagnoses included but were not limited to, CHF (congestive heart failure), history of diabetes mellitus, history of myasthenia gravis, gastrointestinal bleed, dementia, chronic atrial fibrillation, history of chronic deep vein thrombosis (blood clot).</p> <p>A care plan, dated 3/28/12, indicated the resident was at risk for</p>			

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	<p>dehydration related to diuretic use.</p> <p>The resident was discharged to the hospital on 8/9/12 for increasing pedal edema and increasing shortness of breath. The resident returned to the facility on 8/11/12 with a 1500 ml (milliliters) fluid restriction.</p> <p>The intake and output record was not initiated until 8/15/12. The undated fluid restriction worksheet indicated the resident may receive 960 ml with meals (360 ml for breakfast and lunch / 240 ml for supper) and 540 ml from nursing (220 ml for day and evening shift / 100 ml for night shift).</p> <p>On 8/13/12, the resident's lab work indicated (blood urea nitrogen) BUN 37H (normal is 7-22) and Creatinine 1.7H (normal is 0.4-1.5). (These are kidney functioning tests). The resident was receiving Bumex (diuretic/water pill) 2 mg (milligrams) daily.</p> <p>The intake and output record for August 2012 were incomplete on 8/17/12 to 8/20/12, 8/23/12, 8/25/12 to 8/29/12 and 8/31/12. The intake and output record also indicated the resident did not receive the full allowed 1500 ml of fluid per day. On 8/15/12, Resident #40 received only</p>			

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	<p>960 ml of fluid in 24 hours. On 8/16/12, the resident received only 1080 ml of fluid in 24 hours. On 8/21/12, the resident received only 840 ml of fluid in 24 hours. On 8/22/12, the resident received only 560 ml of fluid in 24 hours. On 8/24/12, the resident only received 700 ml of fluid in 24 hours. On 8/30/12, the resident only received 540 ml of fluid in 24 hours.</p> <p>On 9/13/12, the resident's lab work indicated BUN 34H and Creatinine 1.7H.</p> <p>On 9/21/12, the resident's lab work indicated BUN 35H and Creatinine 2.0H.</p> <p>On 9/27/12, the resident's lab work indicated BUN 36H and Creatinine 2.2H.</p> <p>The physician wrote on the lab to discontinue the resident's fluid restriction.</p> <p>The intake and output record for September 2012 indicated the resident did not receive the full allowed 1500 ml of fluid per day. The resident received less than 1100 ml of fluid per 24 hours per day.</p> <p>On 10/4/12, the resident's lab work</p>			

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	<p>indicated (chloride) CL 97L (normal is 99-109); BUN 51H and Creatinine 2.4H.</p> <p>On 10/11/12, the resident's lab work indicated the BUN 55H and Creatinine 2.3H The physician was notified and the Bumex (water pill/diuretic) was discontinued.</p> <p>On 10/18/12, the resident's lab work indicated the BUN 35H and Creatinine 1.8H.</p> <p>The facility did not monitor the resident's fluid intake resulting in abnormal blood work and discontinued water pill that was initiated one month prior for edema and shortness of breath.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services related to assessing a resident's pain prior to administering the resident's as needed pain medication for 1 of 37 residents reviewed for necessary care and services. (Resident #39)</p> <p>Findings include:</p> <p>Resident #39's record was reviewed on 10/23/12 at 9:51 a.m. The resident's diagnoses included, but were not limited to, dementia with associated behavioral symptoms and anxiety.</p> <p>Resident #39's physician's recapitulation orders, dated 10/12/12, indicated an order for Norco (pain medication) 10-325 milligrams, give one tablet every four hours as needed for pain.</p>	F0309	<p>F 309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #39: Resident is assessed for level of pain prior to administration of pain medication. Documentation of this assessment is found on the pain flow sheet. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of residents requiring use of PRN pain medications was conducted by Nursing Administration to insure necessary assessments are completed in conjunction with the medication administration. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been inserviced on the completion of necessary</p>	11/23/2012

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	<p>A care plan, dated 07/11/12, indicated the resident was a risk for alteration in comfort. The approaches included to administer medication as ordered. Evaluate pain intensity, location and level using a scale of 1-10 (worse).</p> <p>The resident's MAR, dated 10/12, indicated the resident received the Norco on 10/08/12 at 10 a.m. The narcotic count sheet indicated the resident also received the as needed Norco on 10/15/12 at 12 p.m. There was a lack of documentation to indicate the resident's pain had been assessed for location and intensity at these times the Norco was administered.</p> <p>The resident's MAR, dated 09/12 indicated the resident received the as needed Norco on 09/03/12 at 10 a.m. and on 09/07/12 at 6 p.m. There was a lack of documentation to indicate the resident's pain had been assessed for location and intensity at these times the Norco was administered.</p> <p>The Pain Flow Sheets, dated 09/12 and 10/12, indicated, "Instructions: Record the following data when implementing an intervention for pain. INTENSITY LEVEL...ABBEY PAIN</p>		<p>assessments related to PRN pain medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to audit 10 pain flow sheets weekly until a threshold of 100% times 90 days for compliance to validate completion of pain assessment prior to administration. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>SCALE (evaluation of pain using visual assessment)..."</p> <p>During an interview on 10/23/12 at 10 a.m., the DoN indicated the staff should have assessed the resident's pain prior to giving the Norco.</p> <p>3.1-37(a)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received treatment and services to prevent infection of a pressure area, related to a dressing change for 1 of 1 dressing change observation. (Resident #56 and Physical Therapist #15)</p> <p>Findings include:</p> <p>During an observation on 10/17/12 at 2:40 p.m., Physical Therapist (PT) #15 prepared to change Resident #56's dressing on the resident's sacrum. PT #15 cleansed the resident's over the bed table with a Prevail wipe (used for skin cleansing), then washed her hands for less than 20 seconds, then applied gloves and then opened up the supplies and placed them on the over the bed</p>	F0314	<p>F 314 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #56: Staff providing wound care treatments have been inserviced with return demonstration of proper technique How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Residents requiring wound care treatments have the potential to be affected by this deficient practice thus all PT, PTA's; Licensed Nurses have completed wound competency education and validated understanding via return demonstration. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</p>	11/23/2012	

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	<p>table.</p> <p>PT #15 then removed the resident's brief, removed the gloves and applied new gloves, then took the resident's dressing off the sacrum area. PT #15 then removed her gloves and washed her hands for 10 seconds, reapplied the gloves and measured the resident's pressure area at 3.1 cm (centimeters) by 2.3 cm with 3 cm depth and undermining at 1.7 cm. PT #15 then washed the pressure area with normal saline and patted the area dry. PT #15 then used tweezers inside the wound, and stated she was trying to remove some of the yellow slough. There had been no handwashing between or gloves changed between cleansing the wound and attempts to remove the yellow slough.</p> <p>PT #15 then began to pack the wound with Prism (wound dressing) with the tweezers. After the pressure area was packed, PT #15 then changed her gloves, without washing her hands, covered the pressure area with the dressing, took gloves off, carried trash bag with the soiled dressing down the hallway to the soiled utility room, then washed her hands for 10 seconds.</p>		<p>recur:Education as per above; new Licensed Nurses; PT; PTA's will complete wound care competency training with return demonstration prior to starting floor orientation.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration and/or Rehab Director will observe 5 applicable staff perform wound care per week until a threshold of 100% times 90 days for compliance and then 3 observations per week until a threshold of 100% times 90 days for compliance and then 1 observation weekly until a threshold of 100% times 90 days for compliance. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>During an interview on 10/17/12 at 3:10 p.m., after the observation, PT #15 indicated she was supposed to wash her hands for 20 seconds, before the treatment and after she removed the old dressing and before she started the new dressing.</p> <p>Resident #56's record was reviewed on 10/18/12 at 10:11 a.m. The resident's diagnoses included, but were not limited to, Stage IV sacral decubitus (full loss of skin tissue) and paraplegia related to spinal cord tumor.</p> <p>A care plan, dated 06/30/12, indicated the resident had an active infection in the sacral pressure ulcer of MRSA (methicillin resistant staphylococcus aureus). The approaches included, encourage good clean hygiene techniques to avoid cross-contamination.</p> <p>A facility policy, dated 05/21/04, and received from the Director of Nursing (DoN) as current, titled, "Wound Care/Treatment Guidelines", indicated, "...Place supplies on a clean surface. A blue pad or wax paper provides a nice clean barrier...Clean hands as outlined in the Hand Hygiene procedure..."</p>						

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	<p>A facility policy, dated 05/21/14, and received from the DoN as current, titled, "Wound Care Procedure for Major Wounds," indicated, "...Set up the supplies on a CLEAN surface at the bedside (cover the surface with a clean impervious barrier before putting the supplies out)...Clean your hands following Hand Hygiene Guidelines...Put gloves on. 9. Remove the soiled dressing...Remove gloves...Clean your hands following Hand Hygiene Guidelines. 13. Put on clean gloves. 14. Clean the wound...Remove gloves and place in bag. 17. Put on new gloves. 18. Apply a clean dressing as ordered. 19. Remove gloves and place in bag...Clean your hands following Hand Hygiene Guidelines..."</p> <p>A facility policy, dated 05/01/12, received from the DoN as current, titled, "Hand Hygiene" indicated, "...Wash well under running water for a minimum of 10 seconds, using a rotary motion and friction..."</p> <p>The manufacturer's instructions for the Prevail wipes, received from the DoN on 10/18/12 at 12:45 p.m., indicated the washcloths cleansed and moisturized the skin and were alcohol free. The instructions lacked documentation to indicate the wipes</p>			

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	could be used for sanitizing and disinfecting resident belongings. 3.1-40(a)(2)			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <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 interview and record review, the facility failed to ensure restoration of as much normal bladder function as possible for 1 of 4 residents reviewed for urinary incontinency. (Resident #51)</p> <p>Findings include:</p> <p>A record review on 10/23/12 at 3 p.m., indicated Resident #51 had diagnoses including, but not limited to: Diabetes Mellitus, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hyperlipidemia, Depression and Dementia. The record indicated the resident had been admitted into the facility on 06/04/12.</p> <p>The "URINARY STATUS</p>	F0315	<p>F 315 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #51 Urinary diary and urinary and urinary incontinence assessment completed. Care plan was updated on 10/23/12 to reflect incontinence. Care Directive has been revised for incontinence. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of resident's urinary incontinence assessments was completed to insure that any resident with a score indicating that the resident is a candidate for a toileting program received appropriate intervention to ensure restoration of as much normal bladder function as</p>	11/23/2012	

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	<p>INTERVIEW --To be completed by nurse on admission (06/04/12) with input from the resident and/or family." indicated the resident was incontinent of bowel and bladder occasionally, had occasional urine leakage, was never treated for leakage, and used briefs and more frequent use of the restroom to help alleviate the problem. The form was not signed by the assessor.</p> <p>An Admission/5 day Minimum Data Set (MDS) Assessment, dated 6/11/12, indicated Resident #51's cognitive status was severely impaired (score of 6), one person physical assistance required for transfers and Activities of Daily Living(ADL) and use of wheelchair. The resident was not on any urinary toileting program. He was occasionally incontinent of urine (less than 7 episodes per week).</p> <p>The "ASSESSMENT FOR BOWEL AND BLADDER TRAINING" completed for Resident #51 on 6/14/12 indicated a score of 12, which indicated he was a "candidate for toileting, timed or scheduled voiding."</p> <p>An undated "URINARY INCONTINENCE ASSESSMENT" indicated the resident was incontinent</p>		<p>possible. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses were inserviced regarding policy and procedure for completing urinary assessment forms and necessary follow through including implementation of a toileting program when applicable. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to audit up to 5 urinary incontinence assessments weekly until a threshold of 100% times 90 days for compliance; then 2 assessments weekly until a threshold of 100% times 90 days for compliance and then 1 assessment weekly until a threshold of 100% times 90 days for compliance to validate completion and need for appropriate toileting program. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>of urine.</p> <p>The quarterly MDS Assessment on 8/31/12 indicated a decline in Resident # 51's cognitive status and was severely impaired (score of 2). He required 1 person physical assistance for transfers and ADL's and used a wheelchair. There was a decline in the resident's incontinence to frequently (7 or more episodes of incontinence per week, but 1 episode of continence) and was not on any urinary toileting program.</p> <p>The CNA's information sheet, received from the Director of Nursing as current on 10/23/12 at 3 p.m., indicated the resident was continent.</p> <p>There was a lack of documentation to indicate the resident had a care plan for his incontinency and a toileting program.</p> <p>The Monthly Flow Reports, dated 06/12, 08/12, and 10/12, received from the MDS Coordinator on 010/22/12 at 12:36 p.m., indicated the resident had 7 incontinent episodes in June, 71 incontinent episodes in August and 121 incontinent episodes on October.</p> <p>There was a lack of documentation</p>			

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	<p>the resident had been assessed for urinary incontinency since 06/14/12.</p> <p>During an interview with the MDS Coordinator on 10/23/12 at 3:34 p.m., she acknowledged the resident's incontinency had declined and the resident had not been started on a personalized toileting program. She indicated the resident should have been reassessed in August.</p> <p>During and interview on 10/23/12 at 3:51 p.m., CNA #6 indicated Resident #51 was always incontinent for her on the 3 to 11 p.m. shift, wore a brief and didn't communicate when he had to urinate or defecate. He would get up for dinner and is able to help transfer, but does not do anything else. She would toilet him before and after dinner and sometimes he would urinate, sometimes not. She indicated he was mostly incontinent.</p> <p>During an interview with the Director of Nurses (DoN) on 10/23/12 at 3:30 p.m., She stated, "He usually tells us when he needs to use the bathroom. The nurses do the 3-day incontinent assessment." The DoN was unable to locate a three-day voiding assessment.</p>			

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	3.1-41 (a)(2)			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to provide the appropriate treatment and services to a resident with a gastrostomy tube (G-tube) related to administration of medications and flushing of the G-tube for 1 of 1 resident with a g-tube observed in the facility. (Resident #101)</p> <p>Findings include:</p> <p>During observation of medication administration on 10/18/12 at 9:35 a.m., LPN #11 prepared Resident #101's medication. LPN #11 then administered five medications individually and purged each medication with a water flush through the G-tube.</p> <p>During interview on 10/23/11 at 3 p.m., LPN#11 indicated with any other resident she would normally</p>	F0322	<p>F 322</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #101 was not affected by the deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Resident's receiving medications via G-tube have the potential to be affected by the deficient practice. Licensed nurses to complete competency and return demonstration related to policy for medication administration via G-tube.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: As per above, Licensed Nurses will</p>	11/23/2012	

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	<p>have medications flow in by gravity. She indicated she "could not do that with Resident #101 medications because we have a lot of trouble with the crushed medications clogging the tubing. During that medication pass, she had to use the de-clogger because one medication went in easily, but the next wouldn't go at all."</p> <p>Review of the "GERIATRIC MEDICATION HANDBOOK, EIGHTH EDITION," page 133 " Medication Administration Via Enteral Tubes." Procedure steps # 12,13, and 14 state: #12 "Flush tubing w/ 15-30 cc of warm water using gravity. Clamp tubing with water in tube." #13 "Pour dissolved diluted med in syringe and unclamp tubing to allow med to flow by gravity." #14 "Flush tubing after med with 15-30 cc water or prescribed amount (if more than one medication, flush with 5 ml of water between each medication)."</p> <p>3.1-44 (a)(2)</p>		<p>complete re-education regarding medication administration via G-tube and will complete competency to validate understanding.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will observe 5 nurses per week for 4 weeks; 3 nurses per week for the next 4 weeks and then 1 nurse for an additional 4 weeks to complete medication administration via G-tube to insure completed correctly. Random observations shall be ongoing to insure continued compliance and re-education to be provided immediately when indicated. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F0323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions were followed to prevent falls for 1 of 4 residents reviewed for falls (Resident #26) and failed to ensure the facility was free of hazards related to unlocked treatment cart, keys left on top of the treatment cart, and dining room supervision which had the potential to affect 7 residents who were eating lunch in the West Unit Dining Room (#12, #41, #44, #54, #59, #61, and #87) and 4 residents who were identified as confused and independently mobile.</p> <p>Findings include:</p> <p>1. Resident #26's record was reviewed 10/22/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Failure to Thrive, Hypertension, HIV+, Hepatitis C, anxiety and depression.</p> <p>An Admission/5-Day Minimum Data</p>	F0323	<p>F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the keys being left on top of the treatment cart. There will be a Licensed Nurse assigned to each dining room during meal service. Resident #26 no longer resides in the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Licensed Nurses and therapy staff reminded to keep keys secured on their person at all times to prevent this deficient practice from occurring again. A Licensed Nurse will be assigned to each dining room during meal service. Full facility audit was completed to insure that fall prevention interventions are in place as directed on care plan and care directive. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	11/23/2012	

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	<p>Set (MDS) Assessment, dated 09/27/12, indicated Resident #26's cognitive status was severely impaired, required 2 person assistance for transfers and Activities of Daily Living(ADL) and use of wheelchair.</p> <p>A careplan written 9/27/12 indicated Resident #26 "is at risk for injuries from falls" and interventions include, but are not limited to: "Keep call light within reach. Offer toileting upon rising, before/after meals, before bed and prn. Sensor alarm to bed related to poor safety awareness. PT as ordered. Notify MD of any concerns. Notify family of any changes, Low bed (9/29/12), Staff education regarding safety, re-educate in use of call light, continue therapy, mat on floor (10/9/12), Staff education- safety , resident education regarding: do not stand without assist even if CNA is in the room, do not 'reposition' on toilet without assist (10/11/12), 15 min checks (visualization of resident by staff) (10/12/12)."</p> <p>A Nurses' Note, dated 9/23/12 at 12 p.m., indicated LPN #5 assessed Resident #26 after the fall. No visible or apparent injury noted. Pressure alarm was added to wheelchair for safety. Physician and family notified</p>		<p>practice does not recur: A licensed Nurse will be assigned to each dining room during meal service. Licensed Nurses and therapy staff were also re-educated on the importance of securing all keys and nursing staff were also inserviced on making resident rounds utilizing the care directives to insure all fall preventative measures are in place as stated. Any concerns will be immediately addressed by the Licensed Nurse caring for the involved resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Department Managers will be responsible to insure that fall preventative measures remain in place for each resident as stated on the care directives. Resident rounds to be completed randomly 3 days per week (at various times of day) until a threshold of 100% times 90 days for compliance and concerns will be addressed by the Licensed Nurse assigned to the involved resident. Nursing Administration, in addition to, Department Managers to audit 5 meals per week until a threshold of 100% times 90 days for compliance (alternating time of meal to encompass all 3 meals) to</p>		

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	<p>of fall.</p> <p>A fall investigation, dated 9/23/12 at 11:55 a.m., with statement by Social Service Director (SSD) indicated Resident #26 was sitting in a wheelchair napping off and on. Resident slid out of wheelchair on to her back. Wheelchair was not in locked position. No visible or apparent signs of injury. Actions indicated were: staff education regarding safety of resident, offer to lay resident down. Follow up indicated therapy for strengthening and medication review.</p> <p>A Nurse's note on 9/24/12, for day shift written by LPN #9, indicated the resident did not use her call light consistently for toileting or transfers.</p> <p>A fall investigation, dated 10/9/12 at 7:10 a.m., with statement by LPN #5, indicated Resident #26 slid out of bed to the floor when trying to transfer to wheelchair, low bed was raised, mat folded by the wall. Resident indicated day CNA had just assisted her. Actions indicated were: staff education regarding safety and re-instruction and encourage resident to use call light for assistance.</p> <p>A nurses note on 10/9/12 at 11:51</p>		<p>insure a Licensed Nurse is in the dining room for supervision for the duration of the meal service. Nursing Administration to randomly check the top of both treatment and medication carts for the presence of keys. In the event keys are not secured by the staff, disciplinary action will be issued. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>a.m., written by LPN #5, indicated Resident #26 slipped out of bed onto her buttocks on the floor, no visible or apparent signs of injury. Physician and mother notified.</p> <p>A fall investigation, dated 10/9/12 at 9:30 p.m., indicated Resident #26 was assisted back to bed, CNA (no longer employed by facility) left to go out into the hallway for ice when resident slipped off of bed. Actions indicated were: CNA involved received a "teachable" moment regarding safety.</p> <p>A Physician order on 10/10/12 indicated Ativan was discontinued.</p> <p>A Nurses note for 10/10/12 at 4:33 a.m., by RN #4, stated "Observed the resident trying to get out of bed without assistance. Instructed resident to use her call light when needing help."</p> <p>A Nurses Note for 10/11/12 at 11:36 p.m., indicated resident fell off of toilet when CNA turned to sink to get wipes for peri care. No visible or apparent signs of injury. Resident medicated for pain in back that was present before fall.</p> <p>A nurses note for 10/12/12 at 7:15</p>			

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	<p>a.m., by LPN #5 indicated Resident #26 started on every 15 minute checks for safety.</p> <p>A Physician order on 10/16/12 indicated Buspar, Klonopin and Remeron were discontinued.</p> <p>During an interview on 10/18/12 at 11:40 a.m., LPN #5 indicated she has tried to get in to care and pay attention to Resident #26 almost as a one to one to try to keep her more satisfied with her care. She also indicated the resident was placed in a room right by the nurse's station so that she would get attention quickly when the pressure alarms sound (bed and chair pressure alarms used). LPN #5 indicated the alarms sound frequently. She indicated this resident has been educated on risks of falling, but ignores the precautions. She indicated Resident #26 stands and doesn't realize how weak she is so her legs collapse under her.</p> <p>During observation on 10/22/12 at 8:55 a.m., Resident # 26 was in her room with the door shut (but not latched). There was no entry, visualization or interaction with any staff observed until 10:03 a.m., when Resident # 26 yelled out once. LPN # 9 immediately responded to the</p>			

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	<p>resident's call. The facility staff failed to check the resident every 15 minutes from 8:55 a.m. to 10:03 a.m. (1 hour and 8 minutes).</p> <p>During an interview on 10/23/12 at 10:50 a.m., CNA #2 indicated recent inservice about handling falls was done early October 2012. She indicated knowledge of the fall risk for Resident #26 as has been documented on the CNA communication sheets and a star on door frame of said resident's room. She indicated this resident likes to do things herself- "so even if she puts a light on for help, she will not wait for help and starts to go ahead so we have to go in immediately. We cannot leave her alone at all."</p> <p>Record review on 10/23/12 at 3:00 p.m. of inservice records for staff education about falls and safety indicated inservices were presented on 8/24/12 and 10/2/12 for all staff.</p> <p>Record review on 10/23/12 at 11:00 a.m., of "Life Care Centers of America, Fall Management Program," designated as current from the Director of Nursing, indicated on page 3 of 3: "Keep beds in lower position after care is completed and don't leave residents sitting on edge of bed</p>			

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	<p>when leaving the room unattended."</p> <p>2. During an observation on 10/17/12 at 3:45 p.m., the treatment cart was in the hallway on the West Unit, outside a closed resident door and without a staff member at the cart. On top of the treatment cart was the key to unlock the cart.</p> <p>During an interview on 10/17/12 at 3:47 p.m., PT #15 indicated normally she does not leave the key on top of the treatment cart.</p> <p>3. During an observation on 10/18/12 at 8:43 a.m., the treatment cart on the West Wing was located in the hallway across from the dining room where the residents were eating. The treatment cart was unattended, there were no staff in the hall and the cart was unlocked. There was creams and ointments in 7 of the 20 drawers and hydrogen peroxide in the bottom drawer of the cart.</p> <p>LPN #11 became aware of the unlocked cart at 8:47 a.m. During an interview at that time, she indicated there were confused residents on the unit who had independent mobilization. She indicated she had pushed the door shut and thought the cart was locked.</p>						

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	<p>A list of residents who are classified as confused and independently mobile was received from the Director of Nursing (DoN) on 10/22/12 at 10:45 a.m. There were four residents listed.</p> <p>A facility policy, dated 05/21/04, and received from the DoN as current, indicated, "...Leave the cart locked and in the hall when not attended during wound treatment..."</p> <p>4. During an observation of the West Unit Dining Room noon meal on 10/15/12 at 12:50 p.m., Residents #87, #54, #44, #59, #41, #12, and #61 was sitting in the dining room. The resident's noon meal had been served.</p> <p>There were no staff in the dining room. LPN #16 was passing medications to residents who were in their rooms. The LPN was back and forth down the hallway away from the dining room, back to the medication cart, which was located across the hall from the dining room.</p> <p>Resident #41 was feeding himself a pureed lunch with thickened fluids and was coughing after swallowing. LPN #16, left the medication cart and</p>			

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	<p>went into a resident's room while the resident was coughing. LPN #16 was away from the opening of the dining room for 30 seconds and the resident had stopped coughing.</p> <p>CNA #14 then came and sat in the dining room.</p> <p>A facility policy, dated 07/23/09, received from the Corporate Nurse Consultant as current, titled, "Dining", indicated, "...a licensed nurse is present in the dining room for each meal..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0328 SS=D	<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: 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, interview and record review, the facility failed to monitor portable oxygen tanks as ordered on a resident with known respiratory distress, in which the oxygen tanks were not turned on, the resident indicated he was short of breath and the oxygen saturations dropped to 87% (normal 90 or over). This affected 1 of 3 people observed for oxygen. (Resident #76)</p> <p>Findings included:</p> <p>On 10/22/12 at 8:30 A.M., Resident #76 was observed propelling himself in his wheelchair going back to his room from the main dining room. The resident's bilateral oxygen tanks were not turned on. The resident indicated he felt short of breath. LPN #9 turned on the residents tanks and checked the oxygen saturation which indicated 87%. The nurse requested an aide to</p>	F0328	<p>F 328 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Licensed Nurse immediately assessed Resident #76 and reapplied the oxygen as ordered per the physician. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of residents' requiring oxygen use was conducted to insure that the oxygen liter flow is being delivered as ordered and documentation on the treatment administration record is complete. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff were re-inserviced on oxygen</p>	11/23/2012

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	<p>go fill the resident's oxygen tanks immediately.</p> <p>Resident #76's clinical record was reviewed on 10/18/12 at 8:30 A.M. Resident #76" diagnoses included but were not limited to, history of terminal heart disease (Elsenmengers Syndrome), history of sick sinus syndrome (heart condition), cardiomegaly, severe pulmonary hypertension, and chronic encephalopathy.</p> <p>The October 2012 Physician Recapitulation orders indicated oxygen to be on at 12 liters per nasal cannula continuously when up in wheel chair, verify oxygen liter flow twice per shift while oxygen was in use, and call physician if oxygen saturations are less than 90%.</p> <p>The October 2012 treatment record was incomplete for verifying oxygen liter flow twice per shift while oxygen was in use. The record only indicated the oxygen was verified once a shift.</p> <p>The September 2012 treatment record was incomplete for verifying oxygen liter flow twice per shift while oxygen was in use. It was also incomplete for 12 liters of oxygen by nasal cannula when up and by</p>		<p>administration and verification of liter flow per the Licensed Nurse twice per shift. C.N.A.'s were reminded that they are not to turn the oxygen tanks on or off. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration will verify oxygen liter flow on 5 residents per week until a threshold of 100% times 90 days for compliance. The audit will also validate that the nurse is completing twice per shift verification of liter flow while oxygen is in use. This documentation appears on the treatment administration record. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>rebreather mask when in bed.</p> <p>A care plan, dated 7/17/12, indicated the resident was at risk for respiratory distress. The interventions included to ... oxygen on as ordered, monitor for signs and symptoms of respiratory distress...</p> <p>An order, dated 4/26/12, indicated to frequently monitor resident's oxygen saturation each shift. The treatment record did not indicate this but indicated an order dated 6/17/11, of checking oxygen saturations as needed for signs and symptoms of respiratory distress.</p> <p>Interview with LPN #9 on 10/19/12 at 2:45 P.M., indicated the resident's oxygen saturation was checked frequently and documented every shift in the treatment record. Upon reviewing the current treatment record, there was no documentation of oxygen saturation being checked.</p> <p>Interview with CNA #8 on 10/22/12 at 1:55 P.M., indicated the responsibility of turning on the oxygen was the nursing staff if they can find them. She also indicated the CNAs' will get permission at times to turn tanks on/off if the nurse is busy.</p>			

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 were free from unnecessary medications related to adequate monitoring and indications for use for pain medication, anti-anxiety medications and blood thinners for 3 of 10 residents reviewed from unnecessary medications. (Residents #39, #52, and #54)</p> <p>Findings include:</p>	F0329	<p>F 329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #39: Per conversation with the resident's physician the PRN Xanax is now discontinued. Resident continues to receive routine dose of Xanax. Resident #54: The Lorazepam is now ordered as a scheduled medication due to consistent need by the resident. Resident #52: Psychiatric Nurse</p>	11/23/2012

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	<p>1. Resident #39's record was reviewed on 10/23/12 at 9:51 a.m. The resident's diagnoses included, but were not limited to, dementia with associated behavioral symptoms and anxiety.</p> <p>A physician order, dated 09/05/12, indicated an order for Xanax (anti-anxiety medication) 0.5 milligrams four times a day as needed for anxiety/restlessness.</p> <p>The Medication Administration Record (MAR), dated 09/12, indicated the as needed Xanax was given on: 9/3 at 9 a.m. for yelling 9/10 at 9 a.m. for yelling 9/10 at 9p.m. for yelling 9/15 at 9 a.m. for yelling 9/16 at 10 a.m. for yelling 9/19 at 9 a.m. for yelling 9/30 at 9 p.m. for increased anxiety</p> <p>There was a lack of documentation to indicate other interventions had been attempted prior to the administration of the as needed Xanax.</p> <p>The MAR, dated 10/12, indicate as needed Xanax was administered on 10/11/12 at 10 a.m. for anxiousness.</p> <p>There was a lack of documentation to</p>		<p>Practitioner to evaluate resident's current psychoactive medication orders on 11/16/12 and make recommendations as deemed necessary. Referral has been made for this resident to see a cardiologist on 12/03/12 in reference to his Anti-coagulant therapy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility audit of PRN Psychoactive medications was completed to validate continued need for the medication and/or insure non-pharmacological interventions were attempted prior to administration of the PRN medication. Full facility audit of residents requiring use of Anti-coagulant therapy has been conducted to identify any resident receiving multiple Anti-coagulant medications. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been inserviced regarding the administration of PRN Psychoactive medications and need to trial 3 non-pharmacological interventions prior to</p>		

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	<p>indicate other interventions had been attempted prior to the administration of the as needed Xanax.</p> <p>During an interview on 10/23/12 at 10:50 a.m., the Director of Nursing (DoN) indicated interventions needed to be attempted prior to giving the as needed Xanax.</p> <p>2. Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip.</p> <p>The physician's recapitulation orders, dated 10/12, included lorazepam (anti-anxiety) 0.5 milligrams every six hours as needed for anxiety originally ordered on 09/12/12.</p> <p>The MAR, dated 09/12, indicated the resident received the as needed lorazepam on September 16 at 6 p.m.; 9/17 at 8 a.m.; 9/18 at 10 a.m.; 9/19 at 8 a.m.; 9/22 at 3 a.m. and 9:30 a.m.; 9/23 at 8 a.m., and 9/ 25 at 1:50 a.m., 2012.</p> <p>There was lack of documentation on the MAR and in the Nurses' Notes to indicate other interventions were attempted prior to giving the resident the as needed lorazepam.</p>		<p>medication administration.Licensed Nurses have received inservice education related to insuring the use of multiple Anticoagulant medications is truly warranted per discussion with the physician.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to review 5 Medication Administration Records weekly until a threshold of 100% times 90 days for compliance to insure that non-pharmacological interventions have been attempted and documented prior to PRN Psychoactive medication being administered. Documentation of interventions trialed shall be reflected on the Medication Administration Record. Nursing Administration to review the clinical records of those residents requiring use of Anti-coagulant therapy on a daily basis (Monday through Friday) until a threshold of 100% times 90 days for compliance. Audit to review for use of multiple Anti-Coagulant medications and the need for continued use, as directed by the physician, in order to avoid unnecessary drug use. Audit results and system components will be reviewed by the QA</p>	

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	<p>The MAR, dated 10/12, indicated the resident received the as needed lorazepam on October 17 at 5 p.m., and 10/18 at 5 p.m., 2012.</p> <p>There was a lack of documentation on the MAR and the Nurses' Notes to indicate other interventions were attempted prior to giving the resident the as needed lorazepam.</p> <p>During an interview on 10/19/12 at 8:50 a.m., LPN #11 indicated the staff are supposed to try three different interventions prior to giving the as needed medication and then document those interventions on the MAR.</p> <p>3. Resident #52's clinical record was reviewed on 10/17/12 at 2:50 P.M. Resident #52's diagnoses included but were not limited to, cerebrovascular accident (stroke) with left hemiplegia (paralysis), edema, deep vein thrombosis (blood clot), and anxiety.</p> <p>A consultation report, dated 2/27/12, requested a GDR (gradual dose reduction)for Ambien and the physician declined without reason on 3/1/12.</p> <p>A consultation report, dated 4/30/12,</p>		Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.				

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	<p>requested for the physician to re-evaluate the combination of Coumadin, Plavix and Aspirin. The resident's previous attending physician indicated on 5/3/12, "NO" with a circle around it and wrote, "you can check with his cardiologist. He has CVA, DVT, while on Plavix & (and) ASA (aspirin), need triple therapy."</p> <p>A consultation report, dated 6/9/12, requested the resident to have a GDR for Ambien (medication for sleep). The resident had the order since July, 2010. The previous attending physician wrote on 6/10/12, "NO: if not broken, don't fix it. Do you know the patient!? I know the patient well." The physician did not indicate the patient-specific rationale describing why a GDR attempt was likely to impair function or cause psychiatric instability in the individual.</p> <p>A care plan, dated 7/11/12, indicated the potential for "mood alteration and complaints of anxiousness and difficulty sleeping." The interventions indicated to "...provide supportive outlet as needed; encourage out of room activities; medication as ordered; 1:1 reassurance as needed..."</p>			

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	<p>A care plan, dated 7/11/12, indicated the resident was on psychotropic medication. The interventions included to administer medication as ordered, observe for any adverse reactions, observe for any changes in mood or behaviors...</p> <p>A care plan, dated 7/11/12, indicated the resident was at risk for "injuries...receives psychotropic medication,...diuretic." The interventions included to keep call light within reach, offer toileting upon rising, before or after meals, before bed and prn (as needed).</p> <p>An order, dated 7/24/12, indicated to increase Xanax (antianxiety medication) from three times a day to four times a day. There was no documentation from nursing indicating increased anxiety.</p> <p>A request for continuance of Ambien was faxed to facility on 8/20/12 and physician signed for continuance for reason of "for sleep (hold if lethargic or sleeping)."</p> <p>A behavior sheet for 7/12 and 8/12 indicated no agitation noted for resident on all three shifts in relation to the resident receiving Xanax.</p>			

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	<p>Consultation Report on 9/27/12 requested GDR for Ambien. The new physician taking over the care declined the recommendation on 10/4/12 and indicated the GDR attempt would likely impair function.</p> <p>A behavior sheet for 9/12 indicated no agitation for the resident on all three shifts in relation to the resident receiving Xanax.</p> <p>A consultation report, dated 10/27/11, requested GDR for Xanax 0.25 mg three times a day (since 12/10) and Remeron 15 mg (3/09). The physician declined on 11/1/11 and indicated to continue use in accordance with the current standard of practice and a GDR attempt is likely to impair function or cause psychiatric instability. The physician wrote, "If not broken don't fix it."</p> <p>A care plan, dated 7/11/12, indicated the resident was at risk for bleeding/bruising due to anti-coagulation medication. The interventions indicated to administer medication as ordered; labs as ordered; pt/inr; observe and assess for signs and symptoms of bleeding-bruising; notify the physician of any concerns...</p>			

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	<p>The October 2012 Physician Recapitulation orders indicated the resident was receiving Plavix (blood thinner/platelet inhibitor) 75 mg (milligrams) every day, Coumadin daily (dosage varies according to labs) and Aspirin 325 mg per day.</p> <p>An interview with Social Service on 10/19/12 at 2:00 P.M., indicated she was trying to go through all the residents records and she will follow up to see if the cardiologist had been contacted and will follow up with the resident's medications for GDR's since there has been a change in physicians. She also indicated she was "gathering behavior information from last month and comparing/carrying over to this month."</p> <p>3.1-48(a)(6)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute food under sanitary conditions, related to food and fluids uncovered during meal pass for 2 of 2 meals observed, which actually affected 15 residents observed with the potential to affect 55 of 55 residents living in the facility. (Residents #9, #12, #14, #26, #40, #54, #56, #59, #61, #62, #68, #70, #86, #87, and #101)</p> <p>Findings include:</p> <p>1. During an observation of the noon meal on the West Unit on 10/15/12 at 12:15 p.m., the following was observed:</p> <p>CNA #14 carried two glasses of uncovered ice tea down the hallway to Resident #101's room.</p> <p>CNA #17 carried Resident #62's tray down the hallway to the resident's room, the cake on the tray was uncovered.</p>	F0371	<p>F 371 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Upon identification of this concern, all food and fluids are now being covered during meal pass. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur: Dietary and Nursing staff were educated on the importance of covering all food and beverages as well as not uncovering the items prior to placing in front of the resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary Manager or Designee to monitor meal delivery 5 times weekly until a</p>	11/23/2012

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	<p>CNA #17 then carried Resident #56's tray through hallway to the resident's room, the cake on the tray was uncovered.</p> <p>CNA #17 then removed Residents #87, #54, #59, #12, and #61's trays from the food cart sitting in the hallway and delivered the food to the residents in the West Unit dining room. The pieces of cake on the trays were uncovered and the coffee served to the residents in cups were uncovered.</p> <p>CNA #14, then sat to assist Resident #87 with her tray set up. CNA #14 wiped her nose with a paper towel then continued to assist Resident #87 with her meal tray.</p> <p>2. During an observation of the noon meal on 10/18/12 at 12:22 p.m. on the West Unit, the following was observed:</p> <p>CNA #14 delivered the noon meal from the food cart in the hallway to Resident #56's room. The cake on the tray was not covered.</p> <p>CNA #14 then poured juice for Resident #62, place it on the food tray, and carried it down the hall to</p>		<p>threshold of 100% times 90 days for compliance (alternating meal times) to insure all food and beverages are covered until placed in front of the resident.</p> <p>Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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	<p>the resident's room. The cake and juice was not covered.</p> <p>Residents #54, #87, #40, #14, all received their noon meals on a tray, with the cake uncovered.</p> <p>3. During observation on 10/15/12 at 12:10 p.m., CNA #10 carried food trays with uncovered cake the length of the East hallway to deliver to Residents #68, #9, #26 in their rooms and to residents in the East dining room.</p> <p>During observation on 10/18/12 at 12:33 p.m., a CNA carried a tray from the food cart and delivered to a room 3 doors away with the dessert uncovered.</p> <p>4. On 10/15/12 from 12:40 P.M. to 1:00 P.M., observed staff placing trays on a rack near the center of the dining room, removing lids and delivering to the residents at their tables. Resident # 86 and #70 received their plates uncovered straight from kitchen. A hallway separates the main dining room and the kitchen. There were 10 in the dining room at this time.</p> <p>On 10/16/12 from 12:45 P.M. to 1:10 P.M., observed staff placing trays on a rack near the center of the dining</p>			

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	<p>room, removing lids and delivering to some of residents at their tables uncovered and observed some trays being exchanged by kitchen staff to dining staff uncovered.</p> <p>Approximately 20 residents were in the dining room at this time.</p> <p>A Resident Dining Service policy dated 1/1/2007 was received by the DON on 10/19/12. The policy indicated ...all food, beverages and flatware are completely covered before transported through the hallways...</p> <p>3.1-21(i)(3)</p>			

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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to securely store medications , maintain proper medication storage temperature and</p>	F0431	F 431 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents	11/23/2012			

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	<p>dispose of expired medication in 2 of 2 medication rooms.</p> <p>Findings include:</p> <p>1) During observation on 10/15/12 at 10:30 a.m., the East medication room was unlocked by LPN #5 for maintenance to work in the room. Maintenance was in the medication room alone and unsupervised by any nursing staff in the medication room or the adjoining nurse's station during the entire time he was in the medication room.</p> <p>LPN #9 at 10:43 a.m., was observed to witness maintenance staff unsupervised in medication room , but did not question or remain to supervise maintenance staff.</p> <p>2) During observation on 10/19/12 at 10:20 a.m., the refrigerator in the West medication room was at a temperature of 42 degrees. LPN #11 indicated she would have maintenance check the refrigerator .</p> <p>During observation 10/19/12 at 12:50 p.m., the West medication refrigerator temperature was 42 degrees. Contents of refrigerator were cold to touch and suppositories were firm. LPN #11 indicated maintenance</p>		<p>were identified as being affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Audit of med room refrigerators was completed to insure that proper medication storage temperature is maintained. Audit of medications stored in the medication refrigerators was completed to insure medications were not expired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director has been inserviced that he, nor any member of his staff, may not be in a medication room unless under Licensed Nurse supervision. Licensed Nurses have been inserviced on this directive. Licensed Nurses also received education regarding checking medication dates for expiration and discarding medications in accordance with manufacturer's guidelines. In addition, Licensed Nurses were also educated related to monitoring refrigerator temperatures in order to maintain proper medication</p>		

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	<p>thought the temperature was off because the unit needed to be defrosted. LPN #11 indicated nursing would take care of defrosting.</p> <p>During observation 10/22/12 at 8:18 a.m., the West medication refrigerator temperature was 40 degrees, but the refrigerator had not been defrosted.</p> <p>3) During observation 10/19/12 at 10:20 a.m., an open vial of tuberculin serum was dated as opened on 8/28/12.</p> <p>A professional resource web site, "cdc.gov/tb/education/mantoux/part1.htm," indicated, "...The label should indicate the expiration date. If it's been open more than 30 days or the expiration date has passed, the vial should be thrown away and a new vial used. When you open a new vial, write the date and your initials on the label to indicate when the vial was opened and who opened it..."</p> <p>3.1-25(m)</p>		<p>storage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:Nursing Administration to audit medication room refrigerators 3 times per week until a threshold of 100% times 90 days for compliance to insure recommended temperature is being maintained for proper medication storage and to verify expiration dates on refrigerated medications. Executive Director to randomly complete medication room observations (3 times per week) until a threshold of 100% times 90 days for compliance to verify that non-licensed personnel are not located in the medication room without Licensed Nurse supervision. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F0441	F 441 What corrective action(s) will be accomplished	11/23/2012			

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	<p>provide a safe and sanitary environment related to handwashing, glove use, glucometer (blood sugar monitoring) cleaning, which had the potential to effect 15 residents who required blood sugar monitoring; failed to store urine collection/measurement appliances, bedpans, bath basins, and toilet risers in a sanitary manner and failed to ensure hand hygiene during medication pass observations. This affected 26 residents' observed. (Residents #5, #6, #7, #10, #14, #20, #23, #26, #27, #31, #33, #45, #47, #52, #53, #54, #56, #59, #63, #66, #70, #71, #73, #76, #101, and #105)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an evening shift medication observation on 10/17/12 at 4 p.m., RN #18 prepared and administered Resident #56's medication. RN #18 touched the resident during the medication administration. After the medications were administered, RN #18 washed her hands for five seconds before leaving the resident's room. 2. During an observation on 10/18/12 at 11 a.m., LPN #5 assisted Resident #105 into bed. LPN #5 took off the resident's shoes and moved the 		<p>for those residents found to have been affected by the deficient practice: No resident's were adversely affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Hand hygiene competency/return demonstration completed on all facility staff by the Staff Development Coordinator in order to insure ongoing compliance and to prevent the deficient practice from potentially affecting other residents. Glucometer cleaning competency /return demonstration completed with Licensed Nurses by Staff Development Coordinator to insure ongoing compliance and to prevent the deficient practice from potentially affecting other residents. Bedpans; bath basins; urine collection/measurement devices and toilet risers are now stored in a sanitary manner in the residents rooms in accordance with facility policy. Any unlabeled resident care equipment was immediately discarded and new items redistributed. What measures will be put into place or what systemic changes will be made to ensure that the</p>				

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	<p>resident's feet up into the the bed. LPN #5 then walked out of the room without washing her hands, walked down the hall to the nurses' station, obtained supplies to perform Resident #105's glucometer, and returned to the resident's room and washed her hands.</p> <p>3. LPN #5 performed a glucometer test on Resident #105, on 10/18/12 at 11:10 a.m. LPN #5 washed her hands and exited the room. LPN #5 then wiped off the glucometer with a Sani-wipe for 15 seconds and laid the glucometer on a paper towel to dry. After two minutes the glucometer was not visibly wet. During an interview at the time of the observation, LPN #5 indicated the glucometer was not visibly wet for three minutes.</p> <p>During an interview and observation on 10/18/12 at 11:33 a.m., LPN #11 demonstrated how to clean a glucometer. LPN #11 applied gloves, placed the glucometer on a paper towel, took a sani cloth from the cart, wiped the glucometer for 40 seconds. The glucometer was visibly wet. LPN #11 then covered the glucometer with a dry paper towel. LPN #11 indicated after one minute the glucometer was a little wet, she indicated after two minutes, the</p>		<p>deficient practice does not recur: Facility staff received inservice training related to hand hygiene and glove use. As per above, Licensed Nurses completed return demonstration related to Glucometer cleaning and reviewed policy related to the instillation of eye drops. Nursing staff were educated on the storage of bedpans; urinals; bath basins; toilet risers; urine collection/measurement devices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to observe 5 Licensed Nurses demonstrate proper Glucometer cleaning weekly until a threshold of 100% times 90 days for compliance; then observe 3 Nurses weekly until a threshold of 100% times 90 days for compliance. Newly hired Nurses will also be required to complete a competency/return demonstration during initial orientation. Nursing Administration to monitor hand hygiene through random selection of facility staff. Nursing administration will observe 10 staff members complete hand hygiene on a weekly basis until a threshold of 100% times 90 days for compliance (including observation on all 3 shifts) to insure compliance. Nursing</p>				

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	<p>glucometer was not visibly wet, LPN #11 indicated, "looks pretty good", and went to place the glucometer in the plastic bag in the medication cart.</p> <p>During an interview and observation on 10/18/12 at 4 p.m., RN #18 cleaned the glucometer. She indicated she cleaned the glucometer every time she used it. RN #18 then wiped the glucometer for 40 seconds with a Sani-cloth. She indicated then she lets the glucometer air dry. During an interview at the time of the observation, she indicated at one minute the glucometer was a "little bit damp." She indicated at 1 1/2 minutes the glucometer was dry.</p> <p>During an interview on 10/19/12 at 4 p.m., the Director of Nursing (DoN) indicated the staff are supposed to use the Sani-cloth and wipe off the glucometer, and let the machine dry for 2-3 minutes.</p> <p>The package of the Sani-Cloth indicated to disinfect a surface, the surface must be thoroughly wet for three minutes.</p> <p>A facility policy, dated 03/12, titled, "Cleaning and Disinfection of the Glucometer", received from the Director of Nursing as current,</p>		Administration to complete resident room rounds to validate proper storage of bedpans; bath basins; toilet risers; and urine collection/measurement appliances. Ten resident rooms will be audited on a weekly basis until 100% threshold times 90 days for compliance and any issues will be immediately addressed. Audit results and system components will be reviewed by the QA Committee monthly with subsequent plans of correction developed and implemented as deemed necessary.	

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	<p>indicated, "...Super Sani-Cloth or Sani-cloth wipe...or an equivalent product that kills hepatitis B and blood-borne pathogens...Follow the manufacturer's guidelines for wet time when applying disinfectant..."</p> <p>4. During an observation on 10/15/12 at 10:27 a.m., Resident #63's bathroom had an uncovered urinal stored on the handrail next to the toilet. During an interview at the time of the observation, LPN #16 indicated the resident shared a bathroom with Resident # 56 and the urinal was used to empty Resident #56's catheter.</p> <p>During an observation on 10/15/12 at 11:10 a.m., Resident #56's closet shelf contained two plastic urine measurement containers, uncovered with a paper towel stuffed down in them. There was an uncovered bedpan and wash basin stored on the floor of the closet. During an interview at the time of the observation, Resident #56 indicated one of the containers was her old roommates.</p> <p>During an observation on 10/15/12 at 12:07 p.m., There was an unlabeled, open tube of skin barrier stored on the back of the toilet. This bathroom</p>			

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	<p>was shared by Residents # 14 and #71. During an interview at the time of the observation, Resident #14 indicated she did not know who the tube of cream belonged.</p> <p>During an observation on 10/16/12 at 8:39 a.m., there was an uncovered bedpan and urinal stored on the rail in Resident #54's bathroom. During an interview at the time of the observation, LPN #11 indicated she was unsure why they were in the bathroom.</p> <p>During an observation on 10/16/12 at 9:06 a.m., Resident #27's bathroom, which she shares with Resident #5 and #23, had a raised toilet seat stored on the floor between the toilet and the wall. During an interview at the time of the observation, CNA #17 indicated Resident #5 will take the toilet riser off the toilet.</p> <p>During an observation on 10/16/12 at 1:59 p.m., Resident #101's bathroom had a wash basin stored on the floor in the bathroom, a plastic measuring container used to measure urine was uncovered and stored on the back of the toilet.</p> <p>During an interview on 10/22/12 at 3:20 p.m., the Staff Development</p>				

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	<p>Coordinator (SDC) indicated she does the inservice with staff for proper hygiene, proper handwashing techniques, and transmission modes of infection. She indicated she had not monitored for handwashing yet, and she had only began her position in the past month. She indicated handwashing is part of the yearly competency. She indicated she had not given a glucometer cleaning inservice.</p> <p>5. On 10/16/12, at 8:40 A.M., a soiled wash cloth was observed in the bathroom on the back on the toilet basin on top of wrapped, unused toilet paper. The bathroom was shared by Residents #53, #47, and #7.</p> <p>At 10/15/12 at 10:15 A.M., a urinal was observed on the hand rail in the bathroom unlabeled and not stored. A very small amount of light yellow fluid was observed in the corner of the urinal. The bathroom was shared by Residents #52, #76, #66 and #73.</p> <p>At 10/16/12 at 8:45 A.M., a urinal was observed on the hand rail in the bathroom unlabeled and not stored. The bathroom was shared by Residents #52, #76, #66 and #73.</p> <p>At 10/17/12 at 9:09 A.M., a urinal was</p>			

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	<p>observed on the hand rail in the bathroom unlabeled and not stored. The bathroom was shared by Residents #52, #76, #66 and #73.</p> <p>At 10/16/12 at 9:20 A.M., a urinal was observed in Resident #76 bottom drawer not covered. A very small amount of light yellow fluid was observed in the base of the urinal.</p> <p>On 10/16/12 at 1:00 P.M., a used, clear plastic graduated measuring cylinder was observed in Resident #45's closet, on the bottom shelf. The daughter indicated the cylinder was used to empty the resident's Foley catheter. The Foley catheter was discontinued on 9/24/12.</p> <p>An interview with the DON (Director of Nursing) on 10/19/12 at 3:15 P.M., indicated the urinals should be stored properly and the cylinder should have been removed and disposed of.</p> <p>An undated, facility policy, titled, "Offering & Removing the Bedpan", received from the Director of Nursing on 10/22/12 at 8:15 a.m., indicated, "...Clean the bedpan. Wipe dry with a clean paper towel. Discard paper towel in waste paper receptacle. Store the bedpan. Do not leave it in the bathroom or on the floor..."</p>			

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	<p>A policy was requested regarding on how and where to store urinals and one was not received by end of survey, 10/24/12.</p> <p>6. During observation on 10/15/12 at 12:23 p.m., CNA #10 helped Resident # 59 to change his pants and assist to the East dining room. The CNA then immediately return to distributing food trays without performing hand hygiene.</p> <p>7. During observation on 10/19/12 at 8:45 a.m.: LPN # 7 was observed to prepare and administer medications touching Resident #26 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #31 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #20 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #70 without washing hands or using hand sanitizer before or</p>			

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	<p>after.</p> <p>LPN # 7 was observed to prepare and administer medications touching Resident #10 without washing hands or using hand sanitizer before or after.</p> <p>LPN # 7 was observed to prepare and administer medications touching Resident #6 without washing hands or using hand sanitizer before or after.</p> <p>8. During observation on 10/19/12 at 10:11 a.m., LPN #7 was observed to prepare and administer medications, touching Resident # 33, including but not limited to instilling eye drops without washing hands or using hand sanitizer before or after, or using gloves.</p> <p>During interview of LPN #7 on 10/19/12 at 10:50 a.m., she indicated she washed her hands at the beginning of shift and she should have washed her hands when she touched the residents and picked up dropped items from the floor and she usually only washed her hands on medication pass when she touched a resident.</p> <p>Record review of Facility policy revised 10/04, titled "POLICIES FOR MEDICATION ADMINISTRATION," received from the Director of Nursing</p>				

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	<p>(DoN) on 10/18/12 at 12:20 p.m., as current, indicated to follow the hand hygiene protocol before and after administration of medication.</p> <p>A facility policy, titled, "Hand Hygiene," dated 05/01/12, and received from the DoN as current, indicated, "...Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction..."</p> <p>Record review of Facility policy titled "EYE INSTILLATION," received from the DoN as current on 10/23/12 at 2:25 p.m., "...1. Wash hands thoroughly before beginning the procedure...6. Should both eyes require instillation, wash your hands before treating the second eye...9. Wash you (sic) hands thoroughly after completing the procedure..."</p> <p>3.1-18(l)</p>			

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents, related to, cracked tiles, gouges out of doors, torn call lights, lime build- up on bathroom sprayer hoses, stained bathroom tiles on 1 of 2 units (West), which had the potential to affect 4 residents who reside in the rooms (Residents #26, #57, #63, and #87), spilled substance on the base heater in the therapy room for 1 of 1 therapy rooms, cluttered activity room for 1 of 1 activity room, and exposed wires on a speaker cord in 1 of 1 kitchens.</p> <p>Findings include:</p> <p>1. During the environmental tour on 10/22/12 at 2:17 p.m. to 3 p.m., with the Maintenance Director, the following was observed:</p> <p>There was a brown substance on the baseboard heater in the therapy room. During an interview at the time of the observation, the Maintenance Director indicated it looked like</p>	F0465	<p>F 465</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The brown substance on the baseboard heater in the therapy room was immediately removed and area cleaned. Resident #57: The gouges in the bathroom door, scrapes on the wall in the bathroom, stained and cracked floor tiles and gouges have been repaired. Resident #26: The pad for the floor has been replaced. Resident #63: Bathroom sprayer has been cleaned. Resident #87: Soft call light has been replaced. The Activity Room has been cleared of numerous boxes and plastic bins. The exposed copper wires located in the kitchen have been secured and are currently non-functional. The window sills in the kitchen have been cleaned and the rusty areas noted to the ceiling have been repaired as well as the rusty air vents over the serving table.</p> <p>How other residents having the potential to be affected by the</p>	11/23/2012	

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	<p>something spilled.</p> <p>Resident #57's bathroom had gouges out of the bathroom door, scrapes on the wall in the bathroom, stained and cracked floor tiles. During an interview at the time of the observation, the Maintenance Director acknowledged the cracked floor tiles and gouges.</p> <p>Resident #26's room had a pad for the floor, which was torn and cracked.</p> <p>2. During observations of resident's rooms, the following were observed:</p> <p>10/15/12 at 10:27 a.m., Resident #63's bathroom sprayer had a build up of lime on the sprayer head.</p> <p>10/15/12 at 2:54 p.m., Resident #87's soft call light was torn and had cracks.</p> <p>During an interview on 10/22/12 at 2:17 p.m., the Maintenance Director indicated the sprayers in the bathrooms are no longer used.</p> <p>3. During daily observations of the Activity room on October 15, 16, 17, 18, 19, 22, and 23, 2012, there were numerous boxes stored and stacked on the floor in several areas of the</p>		<p>same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>Environmental rounds have been completed by the Maintenance and Housekeeping Directors and identified issues were immediately corrected.</p> <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> <p>Department managers have been educated on identifying and reporting maintenance related issues as they conduct their routine resident room rounds.</p> <p>Maintenance Director to include identified areas in the preventative maintenance program and will conduct routine rounds according to facility protocol.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Department managers to conduct resident room observations during their Guardian Angel rounds 3 times weekly and will report any maintenance related issues to the Maintenance Director upon identification of concern. Any areas of concern identified via the environmental rounds will be addressed in a timely manner.</p> <p>Audit results and system components will be reviewed by the</p>				

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	<p>Activity Room.</p> <p>There were plastic bins and clear garbage bags stored and stacked on the boxes and bins and on chairs in the Activity Room.</p> <p>During an interview on 10/23/12 at 6 p.m. the Director of Nursing indicated the Activity room is used by all residents in the building.</p> <p>3. On 10/18/12 between 12:20 P.M. to 12:35 P.M., a long white cord with exposed copper wires (attached to a ceiling pipe) was observed hanging over a silver box labeled, "Wet Chemical Fire Suppression System" located above the sink in the kitchen. The window sills were observed to be dirty with black debris. A few rusty colored areas was observed on the ceiling behind wire/pipe. The three air vents over the serving table was observed to be rusty as well.</p> <p>An interview with the Dietary Manager, at this time, indicated the kitchen was cleaned daily by kitchen staff and the wall was recently fixed by maintenance. The Maintenance Supervisor came in immediately and indicated the wires were from a</p>		QA Committee with subsequent plans of correction developed and implemented as deemed necessary.				

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	<p>speaker he had taken down and had not replaced and indicated the wires would produce "very little juice."</p> <p>3.1-19(f)</p>			

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F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <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 record review and interview, the failed to ensure the facility QAA (Quality Assessment and Assurance) committee identified system failures concerning infection control, psychotropic medications and care planning, which had the potential to affect 28 residents reviewed for QAA. (Residents #5, #6, #7, #10, #14, #20, #23, #26, #27, #31, #33, #39, #45, #47, #52, #53, #54, #56, #57, #59, #63, #66, #70, #71, #73,</p>	F0520	F 520 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #39: The resident's care plan has been updated to reflect the resident's feelings. Resident #101: The resident's care plan has been updated to include the resident's feelings of depression and refusal of treatment to her pressure ulcer. Physician is aware of	11/23/2012

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	<p>#76, #101, #105)</p> <p>Findings include:</p> <p>1. During an interview on 10/22/12 at 3:51 p.m., with the Executive Director (ED) and the Director of Nursing (DoN), the DoN indicated she was unaware of care plans not written, revised and care plan conferences not held. She indicated they have not looked at these concerns with QAA. She indicated the Social Service Director sends out the letters to the family and resident for the care plan conference.</p> <p>The ED indicated when the facility converted to the new software around May or June, nothing transferred from the old system. He indicated the care plans were still viewable but couldn't do anything with it except print them out and retype them and there were delays getting that done. He indicated the MDS (Minimum Date Set) Coordinator been going through the care plans.</p> <p>A) Resident #39's record was reviewed on 10//23/12 at 9:51 a.m. The resident's diagnoses included, but were not limited to, dementia with associated behavioral symptoms and anxiety.</p>		<p>the resident's refusal of treatment. Resident #54: The resident's care plan has been updated to indicate the need for Lorazepam use and preventative measures for heel blister. Resident #53: Resident's care plan has been amended to include her preference for staying up later in the evening and desire to sleep in later in the morning. Resident #45: Resident's care plan now includes "end of life" comfort measures including signs and symptoms of physical and mental decline. Resident #33: Coumadin use is now reflected on the resident's plan of care. Resident #105: Care plan amended to include diagnosis of Parkinson's Disease and use of psychoactive medications. Resident #59: Macular Degeneration is now reflected on the resident's plan of care. The Anti-coagulant therapy has been discontinued as resident is now comfort measures. Resident # 63: A care plan conference was held on 11/05/12 with both the resident and the family in attendance. Resident #71: A care plan conference was held on 10/31/12 and the plan of care was reviewed with both the resident and family. Resident #57: A care plan conference</p>				

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	<p>A care plan, dated 07/11/12, indicated the resident had dementia with agitation and had a history of yelling out and was disruptive to others. The approaches included, administer medications as ordered, offer snacks, toileting repositioning, activities. and one on one visits, rule out medical conditions/pain, redirect to activity: tv/music, notify the resident's family of any changes and encourage them to visit, notify the physician of any concerns, refer to Psychology as ordered and on 09/05/12 medication change was added.</p> <p>A physician order, dated 8/8/12, indicated an order to increase the resident's Xanax (anti-anxiety medication) from 0.5 milligrams twice a day to three times a day.</p> <p>A physician's order on 09/05/12 indicated to increase the Xanax to four times a day.</p> <p>A Hospice note, dated 09/05/12, indicated the resident had increased feelings of being fearful and/or scared and the physician had been notified and the resident's Xanax had been increased.</p> <p>The resident's care plan indicated a</p>		<p>has been scheduled per resident's request for 11/20/12.</p> <p>Resident #39: Per discussion with the physician, the resident's Xanax has now been scheduled versus for PRN use.</p> <p>Resident #54: Care plan now reflects resident's current behaviors and Social Service intervention. Staff Development Coordinator has completed Hand Hygiene competency training and return demonstration with all facility staff. Staff Development Coordinator has completed competency training related to Glucometer cleaning with Licensed Nurses. Resident #63: Urinal immediately discarded and new one issued to resident and maintained at bedside. Resident #56: Urinals; bedpan; wash basin were immediately discarded and new items were provided to resident and stored at bedside. Resident #14 and #71: Tube of unlabeled ointment was immediately discarded and replaced. Resident #54: Urinal and bedpan was discarded and new items provided to resident. Resident #27; #5; #23: Shared bathroom. Toilet riser removed from bathroom and replaced with a new one. Riser will remain on the toilet in the bathroom versus being set on</p>		

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	<p>lack of documentation of a problem the resident was fearful and/or scared.</p> <p>During an interview on 10/23/12 at 11:30 a.m., the Social Service Director indicated she had not been aware the Xanax had been increased due to fear. She indicated she could not recall being told. She indicated they discuss increase in medications in the morning meetings and she had just started at the facility in June and was now monitoring the medications more closely.</p> <p>B) Resident #101's record was reviewed on 10/22/12 at 11:09 am. The resident's diagnoses included, but were not limited to, metastatic cancer and stage four (full thickness tissue loss) pressure ulcer to the coccyx.</p> <p>An Admission Minimum Data Set Assessment, dated 09/20/12, indicated the resident's cognition was intact and the resident was moderately depressed.</p> <p>A care plan, dated 09/20/12, indicated the resident was admitted with a stage four pressure ulcer. The approaches included, "...Staff to assist with positioning on routine</p>		<p>the floor. Resident #101: Basin and urine collection device was removed from the resident's room and discarded. New items provided. Resident #53; #47; #7: Soiled washcloth immediately discarded and bathroom sanitized. Resident #52; 76; #66; #73: Shared bathroom for these identified resident's. Urinal discarded and replaced. Will be stored in bottom drawer of bedside table. Resident #45: Urine collection device was removed and discarded from resident's closet. New item replaced. Resident #59: C.N.A. #10 re-educated on proper hand hygiene. LPN #7: Received inservice education regarding proper hand hygiene associated with medication administration and instillation of eye drops. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Hand Hygiene competency/return demonstration provided for all facility staff to insure that the deficient practice does not reoccur. Full facility audit of resident care plans/care conference attendance records has been completed by the Social Service Director to validate that care conferences are scheduled accordingly with both the resident</p>				

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	<p>rounds...Treatment as ordered..."</p> <p>The resident's care plan, dated 09/20/12, lacked documentation to indicate the resident was depressed.</p> <p>The physician's recapitulation orders, dated 10/12, indicated an order dated 09/14/12 for Physical Therapy to perform the resident's treatment on the stage four area three times a week and for nursing to complete the treatment on the other four days.</p> <p>The Treatment Administration Record (TAR), dated 10/12 indicated the resident refused the treatment to the stage four area on October 2, 3, 4, 9,10,11,13,14,16,17,18,19,20, and 21, 2012</p> <p>There was a lack of documentation on the TAR and in the Nurses' Notes to indicate the reason for the refusal of the treatment.</p> <p>The resident's care plan, dated 09/20/12, lacked documentation to indicate the resident was depressed and had been refusing treatments to the pressure area.</p> <p>During an interview on 10/16/12 at 9:24 a.m., the Director of Nursing indicated the resident doesn't get out</p>		<p>and family member. Invitations via letter format have been sent to family members of the residents scheduled for a care plan conference and updated conference schedules have been provided to the members of the interdisciplinary team. Social Service Director received education regarding insuring a resident's plan of care is reflective of any behaviors; psychoactive medications; scheduling care plan conferences; coordinating Hospice (end of life) interventions. Staff Development Coordinator completed competency training/return demonstration related to Glucometer cleaning to Licensed Nurses. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff have been educated regarding proper storage of resident care items including: urinals; bedpans; wash basins; urine collection measuring device. Social Service Director has been re-educated on the procedure for scheduling care plan conferences and inviting all appropriate parties. Care plan conferences will be scheduled in accordance with the quarterly MDS schedule, and as needed, based on resident</p>		

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	<p>of bed, and doesn't come out of the room. She indicated the resident was very depressed</p> <p>C) Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip. The resident was admitted to the facility on 09/12/12.</p> <p>C1) Resident #54's physician's recapitulation orders, indicated an order originally dated on 09/12/12, for lorazepam (anti-anxiety) 0.5 milligrams every six hours as needed for anxiety.</p> <p>The MAR, dated 09/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>09/15 at 10 a.m. 09/16 at 10 a.m. 09/17 at 10 a.m. 09/18 at 10 a.m. and 10 p.m. 09/19 at 8 a.m. and 9 p.m. 09/22 at 3 a.m. and 4 p.m. 09/23 at 8 a.m. 09/25 at 1 a.m.</p> <p>The back of MAR indicated the resident received the lorazepam on</p>		<p>need or change of condition. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to observe 5 Licensed Nurses weekly demonstrate proper Glucometer cleaning until a threshold of 100% times 90 days for compliance; then observe 3 Nurses weekly until a threshold of 100% times 90 days for compliance . Newly hired Nurses will also be required to complete a competency/return demonstration during initial orientation.Nursing Administration to monitor hand hygiene through random selection of facility staff. Nursing administration will observe 10 staff members complete hand hygiene on a weekly basis until a threshold of f100% times 90 days for compliance (including observation on all 3 shifts) to insure compliance.Nursing Administration to complete resident room rounds to validate proper storage of bedpans; bath basins; toilet risers; and urine collection/measurement appliances. Ten resident rooms will be audited on a weekly basis until a threshold of 100% times 90 days for compliance and any issues will be immediately addressed. Nursing Administration to complete resident room rounds to validate proper storage of bedpans; bath basins; toilet risers; and urine</p>				

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	<p>September 17 (sic) at 8 a.m., 17 at 10 a.m., 19 at 8 a.m. and 9 p.m., 22 at 9:30 a.m. and 23 at 8 a.m. for complaints of anxiety.</p> <p>The MAR, dated 10/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>10/06 at 8:30 a.m. and 8:30 p.m. 10/15 at 2 p.m. 10/17 at 5 p.m. 10/18 at 5 p.m.</p> <p>The back of the MAR indicated the resident received the lorazepam on October 6 at 8:30 a.m. and 8:30 p.m., and 15, 2012 for yelling out.</p> <p>The progress notes indicated:</p> <p>Nurses' Note, 09/22/12 at 10:36 p.m., indicated the resident was yelling from her room she wanted to go home and requested the an as needed pain medication.</p> <p>Social Service note, dated 09/24/12 at 9:55 a.m., indicated the resident was cursing and disrobing.</p> <p>Nurses' Note, dated 10/01/12 at 9:45 a.m., indicated the resident yells out at times.</p>		<p>collection/measurement appliances. The Executive Director will be responsible to insure that the care plan conference schedule is in accordance with the MDS schedule and invitation letters are mailed in a timely manner. This audit will be completed on a monthly basis. Nursing Administration will audit 5 resident care plans twice weekly until a threshold of 100% times 90 days for compliance; then once weekly until a threshold of 100% times 90 days for compliance and then once monthly until a threshold of 100% times 90 days for compliance to insure that the care plan addresses the resident's current care related needs. Audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>The resident's care plan, dated 09/20/12, indicated the resident was on psychotropic medications (anti-anxiety) and was at a risk for adverse reactions to the medication. The Approaches included to give the medication as ordered and observe for signs and symptoms of adverse reactions.</p> <p>The care plan lacked documentation of the resident's behaviors and reason for the use of the lorazepam.</p> <p>During an interview on 10/18/12 at 3:45 p.m., CNA #12 indicated the resident had occasional behaviors, usually at night. She indicated the resident gets agitated and yells and curses. She indicated the resident is alright as long as someone is in the room, but the yelling starts up when the staff leave the room.</p> <p>During an interview on 10/19/12 at 8:55 a.m., the Social Service Director indicated the resident did not have a care plan for her behaviors.</p> <p>C.2.) Resident #54's care plan, dated 9/17/12, indicated the resident was a risk for pressure ulcers. The approaches included a pressure reducing mattress, preventative skin</p>				

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	<p>care, assist with positioning on routine rounds and as needed, and check skin during care and bathing.</p> <p>On 10/3/12, the care plan was revised to include a left heel blister and an approach for treatment change was added.</p> <p>During an interview 10/18/12 at 3:45 p.m., CNA #12 indicated she would elevate the resident's heels off the bed.</p> <p>During an interview on 10/18/12 at 9:33 a.m., the Minimum Data Set Nurse indicated the care plan had not been revised to include keeping the resident's heels off the bed. She indicated the nurses should have revised the care plan.</p> <p>D) Resident #53's clinical record was reviewed on 10/22/12 at 9:14 A.M. Resident #53's diagnoses included but were not limited to dementia, diabetes mellitus, congestive heart failure, shortness of breath and chronic obstructive pulmonary disease.</p> <p>An Activity Progress note dated 3/17/12 to 3/23/12 indicated it wasn't very important for the resident to choose her bedtime. The note also</p>			

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	<p>indicated the resident ate most meals in the main dining room, she reads and watches TV daily.</p> <p>A quarterly dietary note on 9/10/12 indicated the resident eats all meals in the main dining room.</p> <p>On 10/15/12 at 9:14 A.M., observed the Resident #53 to be in bed.</p> <p>On 10/15/12 at 10:30 A.M., observed the resident to be in bed asleep.</p> <p>On 10/15/12 at 11:45 A.M., observed the resident to be in bed. During this time, the resident was interviewed and she indicated she did not sleep well and was very sleepy.</p> <p>On 10/15/12 at 3:15 P.M., observed the resident to be in bed asleep.</p> <p>On 10/16/12 at 8:45 A.M., observed the resident to be in bed asleep.</p> <p>On 10/19/12 at 8:30 A.M., observed the resident to be in bed asleep.</p> <p>On 10/22/12 at 8: 35 A.M., observed the resident to be in bed asleep.</p> <p>Interview with CNA #6 on 10/22/12 at 1:40 P.M., indicated the resident didn't want to get up because she</p>			

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	<p>was sleepy.</p> <p>Interview with LPN #5 on 10/23/12 at 8:30 A.M., indicated the resident stays up most of the night and likes to sleep in the mornings. She also indicated the resident is not a breakfast person and will get up for lunch.</p> <p>There were no care plans regarding the resident's daily preference of sleeping in/staying up late.</p> <p>E) Resident #45's clinical record was reviewed on 10/19/12 at 10:15 A.M. Resident #45's diagnoses included but were not limited to old cerebral vascular accident (stroke), chronic kidney disease, diabetes mellitus, and septic syndrome.</p> <p>October 2012 Physician Recapitulation orders indicated on 5/30/12, the resident was admitted to hospice and the resident was on oxygen at 2L (liters) per N/C (nasal cannula).</p> <p>An interview with the Social Service Director on 10/19/12 at 2:00 P.M., indicated she was newly hired in June and she was trying to go through all the residents' records to see who needed a care plan. She also</p>						

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	<p>indicated there was a lapse of time from social worker to social worker and the designee social worker did the best she could.</p> <p>There is no care plan indicating care/comfort measures for end of life, including signs and symptoms of physical/mental decline.</p> <p>F) Resident #33's clinical record was reviewed on 10/18/12 at 9:00 A.M. Resident's #33's diagnoses included but were not limited to deep vein thrombosis, congestive heart failure, dementia, and Alzheimer's disease.</p> <p>A nursing note, dated 7/18/12 at 11:58 A.M., indicated the resident was receiving 5mg of Coumadin and was increased to 7.5 mg.</p> <p>A nursing note, dated 7/21/12 at 9:34 P.M., indicated the resident was found to have had a bruise on her right knee. An investigation report indicated the resident to be on Coumadin.</p> <p>The October 2012 Physician Recapitulation orders indicated the resident was receiving Coumadin (blood thinner) daily.</p> <p>An interview with LPN #7 on 10/22/12</p>			

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	<p>at 11:30 A.M., indicated floor nurses are able to initiate care plans.</p> <p>Review of the care plans indicated a care plan related to the use of Coumadin had not been developed.</p> <p>G) Resident #105's clinical record was reviewed on 10/17/12 at 1:20 P.M.</p> <p>A dictated neurology visit report for 10/9/12 indicated the resident to be on Risperdal at bedtime on 10/1/12.</p> <p>A physician exam note for 10/11/12 indicated Resident #105 to have had severe Parkinson's with dementia. Resident #105 also had increased rigidity. Klonopin was used for symptom management of Parkinson's disease.</p> <p>A social service note, dated 10/12/12 at 2:57 P.M., indicated the Risperdal was ordered by a neurologist and was prescribed for hallucinations.</p> <p>An interview on 10/19/12 at 2:00 P.M. with the Social Service Director indicated she had just went through his information and was working on his careplan.</p> <p>There was no care plan for the</p>			

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	<p>psychoactive medications or a care plan for the Parkinson's disease.</p> <p>H) Resident #59 clinical record was reviewed on 10/18/12 at 2:50 P.M. Resident's #59 diagnosis included but were not limited to macular degeneration disease, urosepsis, diabetes mellitus, leukocytosis, cerebrovascular disease, and congestive heart failure.</p> <p>The 9/13/12 Admission Assessment indicated the resident wore glasses and had macular degeneration.</p> <p>MDS 3.0 Activity Progress note, dated 9/13/12 to 9/20/12, indicated the resident as having macular degeneration and was not able to read print easily.</p> <p>The Physician Recapitulation orders for October 2012 indicated the resident was receiving Aggrenox (blood thinner/prevent clotting) twice a day for cerebrovascular disease.</p> <p>Interview with LPN #7 on 10/22/12 at 11:30 A.M., indicated floor nurses are able to initiate care plans.</p> <p>There was no care plan regarding the macular degeneration disease or the use Aggrenox (platelet inhibitor/blood</p>			

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	<p>thinner).</p> <p>I.) Resident #63's record was reviewed on 10/22/12 at 8:20 am. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p> <p>The Care Plan Conference Record in the clinical record indicated the last date the resident had a care plan conference with/or without the resident and responsible party/family was 10/26/11.</p> <p>During an interview on 10/22/12 at 8:45 a.m., the Housekeeping Supervisor, indicated she scheduled the care plan conferences prior to the Social Service Director starting in June. She indicated she had left a message for the family in March of 2012 to set up a care plan conference, but there was nothing to confirm that this was completed. She acknowledged there had been no other care plan conference since 10/26/11.</p> <p>J) During a family interview on 10/16/12 at 3:41 p.m., Resident #71's family indicated they had not been invited to a care plan conference in a long time.</p>						

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	<p>Resident #71's record was reviewed on 10/18/12 at 9 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke.</p> <p>The Care Plan Conference Record in the clinical record indicated the last date the resident had a care plan conference with/or without the resident and responsible party/family was 02/17/11.</p> <p>A Social Service Progress Note, dated 03/22/12, indicated the facility left a message with the resident's son to set up a care plan meeting. The notes lacked documentation of any further attempts to set up a care plan meeting.</p> <p>During an interview on 10/19/12 at 9:50 a.m., the Social Service Director (SSD) indicated she sends letters to the family and resident for a quarterly care plan review then she documents on the Care Plan Conference Record. Further interview with the SSD at 9:55 a.m., indicated there had not been a letter sent out to the resident's family. The SSD indicated no care plan conference had been done since 02/17/11. She indicated care plan conferences should be done quarterly. She indicated she started the SSD position in June and she is</p>			

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	<p>now looking to see what residents' care plans need done.</p> <p>K) Resident #57's record was reviewed on 10/18/12 at 8:35 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and hypertension.</p> <p>The Care Plan Conference Record in the clinical record, indicated the last date the resident had a care plan conference with/or without the resident and responsible party/family was 6/06/11.</p> <p>During an interview on 10/22/12 at 8:45 a.m., with the Housekeeping Supervisor, she indicated the resident was invited to the care plan conference on 4/30/12 and declined to come. She indicated there had not been another invitation to the care plan meeting since then.</p> <p>2. During an interview on 10/22/12 at 3:51 p.m. with the ED and the DoN, the DoN indicated psychotropic drug use is discussed in QAA per the pharmacy report. She indicated the Social Service Director just started in June and "she was working on that."</p> <p>During an interview on 10/23/12 at 11:30 a.m., the Corporate Nurse</p>						

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	<p>Consultant indicated the QAA for psychotropic medications needed, "tightened up."</p> <p>A) Resident #39's record was reviewed on 10/23/12 at 9:51 a.m. The resident's diagnoses included, but were not limited to, dementia with associated behavioral symptoms and anxiety.</p> <p>A physician order, dated 09/05/12, indicated an order for Xanax (anti-anxiety medication) 0.5 milligrams four times a day as needed for anxiety/restlessness.</p> <p>The Medication Administration Record (MAR), dated 09/12, indicated the as needed Xanax was given on: 9/3 at 9 a.m. for yelling 9/10 at 9 a.m. for yelling 9/10 at 9 p.m. for yelling 9/15 at 9 a.m. for yelling 9/16 at 10 a.m. for yelling 9/19 at 9 a.m. for yelling 9/30 at 9 p.m. for increased anxiety</p> <p>There was a lack of documentation to indicate other interventions had been attempted prior to the administration of the as needed Xanax.</p> <p>The MAR, dated 10/12, indicated as needed Xanax was administered on</p>			

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	<p>10/11/12 at 10 a.m. for anxiousness.</p> <p>There was a lack of documentation to indicate other interventions had been attempted prior to the administration of the as needed Xanax.</p> <p>During an interview on 10/23/12 at 10:50 a.m., the Director of Nursing (DoN) indicated interventions need attempted prior to giving the as needed Xanax.</p> <p>B) Resident #54's record was reviewed on 10/18/12 at 8:09 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and fracture to the left hip. The resident was admitted to the facility on 09/12/12.</p> <p>Resident #54's physician's recapitulation orders, indicated an order originally dated on 09/12/12, for lorazepam (anti-anxiety) 0.5 milligrams every six hours as needed for anxiety.</p> <p>The MAR, dated 09/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>09/15 at 10 a.m. 09/16 at 10 a.m.</p>			

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	<p>09/17 at 10 a.m. 09/18 at 10 a.m. and 10 p.m. 09/19 at 8 a.m. and 9 p.m. 09/22 at 3 a.m. and 4 p.m. 09/23 at 8 a.m. 09/25 at 1 a.m.</p> <p>The back of MAR indicated the resident received the lorazepam on September 17 (sic) at 8 a.m., 17 at 10 a.m., 19 at 8 a.m. and 9 p.m., 22 at 9:30 a.m. and 23 at 8 a.m. for complaints of anxiety.</p> <p>The MAR, dated 10/12, indicated the resident received the as needed lorazepam on the following dates and times:</p> <p>10/06 at 8:30 a.m. and 8:30 p.m. 10/15 at 2 p.m. 10/17 at 5 p.m. 10/18 at 5 p.m.</p> <p>The back of the MAR indicated the resident received the lorazepam on October 6 at 8:30 a.m. and 8:30 p.m., and 15, 2012 for yelling out.</p> <p>The progress notes indicated:</p> <p>Nurses' Note, 09/22/12 at 10:36 p.m., indicated the resident was yelling from her room she wanted to go home and requested the an as</p>				

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	<p>needed pain medication.</p> <p>Social Service note, dated 09/24/12 at 9:55 a.m., indicated the resident was cursing and disrobing.</p> <p>Nurses' Note, dated 10/01/12 at 9:45 a.m., indicated the resident yells out at times.</p> <p>The resident's care plan, dated 09/20/12, indicated the resident was on psychotropic medications (anti-anxiety) and was at a risk for adverse reactions to the medication. The approaches included to give the medication as ordered and observe for signs and symptoms of adverse reactions.</p> <p>The resident's record lacked documentation of Social Service interventions to the resident's behavior.</p> <p>During an interview on 10/19/12 at 8:55 a.m., the Social Service Director indicated there was no Social Service documentation of resident's continued behaviors. She indicated she had not been addressing the problem. She indicated she should have been aware the resident had been receiving the lorazepam for anxiety. She indicated she could not recall</p>			

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	<p>being informed about the lorazepam.</p> <p>3, During an interview on 10/22/12 at 3:20 p.m., with the Staff Development Coordinator (SDC), she indicated she had not done monitoring for handwashing in the month she had started at the facility. She indicated handwashing is part of competency check list completed on a yearly basis. She indicated she completed an inservice on infection control and did a quiz, but had not observed staff for proper handwashing. She indicated she has not observed glucometer cleaning.</p> <p>A) During an evening shift medication observation on 10/17/12 at 4 p.m., RN #18 prepared and administered Resident #56's medication. RN #18 touched the resident during the medication administration. After the medications were administered, RN #18 washed her hands for five seconds before leaving the resident's room.</p> <p>B) During an observation on 10/18/12 at 11 a.m., LPN #5 assisted Resident #105 into bed. LPN #5 took off the resident's shoes and moved the resident's feet up into the the bed.</p>				

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	<p>LPN #5 then walked out of the room without washing her hands, walked down the hall to the nurses' station, obtained supplies to perform Resident #105's glucometer, and returned to the resident's room and washed her hands.</p> <p>C) LPN #5 performed a glucometer test on Resident #105, on 10/18/12 at 11:10 a.m. LPN #5 washed her hands and exited the room. LPN #5 then wiped off the glucometer with a Sani-wipe for 15 seconds and laid the glucometer on a paper towel to dry. After two minutes the glucometer was not visibly wet. During an interview at the time of the observation, LPN #5 indicated the glucometer was not visibly wet for three minutes.</p> <p>During an interview and observation on 10/18/12 at 11:33 a.m., LPN #11 demonstrated how to clean a glucometer. LPN #11 applied gloves, placed glucometer on a paper towel, took a sani cloth from the cart, wiped the glucometer for 40 seconds. The glucometer was visibly wet. LPN #11 then covered the glucometer with a dry paper towel. LPN #11 indicated after one minute the glucometer was a "little wet." She indicated after two minutes, the glucometer was not visibly wet, LPN #11 indicated, "looks</p>			

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	<p>pretty good," and went to place the glucometer in the plastic bag in the medication cart.</p> <p>During an interview and observation on 10/18/12 at 4 p.m., RN #18 cleaned the glucometer. She indicated she cleaned the glucometer every time she used it. RN #18 then wiped the glucometer for 40 seconds with a Sani-cloth. She indicated then she lets the glucometer air dry. During an interview at the time of the observation, she indicated at one minute the glucometer was a little bit damp. She indicated at 1 1/2 minutes the glucometer was dry.</p> <p>During an interview on 10/19/12 at 4 p.m., the Director of Nursing (DoN) indicated the staff are supposed to use the Sani-cloth and wipe off the glucometer, and let the machine dry for 2-3 minutes.</p> <p>The package of the Sani-Cloth indicated to disinfect a surface, the surface must be thoroughly wet for three minutes.</p> <p>A facility policy, dated 03/12, titled, "Cleaning and Disinfection of the Glucometer", received from the Director of Nursing as current, indicated, "...Super Sani-Cloth or</p>				

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	<p>Sani-cloth wipe...or an equivalent product that kills hepatitis B and blood-borne pathogens...Follow the manufacturer's guidelines for wet time when applying disinfectant..."</p> <p>D) During an observation on 10/15/12 at 10:27 a.m., Resident #63's bathroom had an uncovered urinal stored on the handrail next to the toilet. During an interview at the time of the observation, LPN #16 indicated the resident shared a bathroom with Resident # 56 and the urinal was used to empty Resident #56's catheter.</p> <p>During an observation on 10/15/12 at 11:10 a.m., Resident #56's closet shelf contained two plastic urine measurement containers, uncovered with a paper towel stuffed down in them. There was an uncovered bedpan and wash basin stored on the floor of the closet. During an interview at the time of the observation, Resident #56 indicated one of the containers was her old roommates.</p> <p>During an observation on 10/15/12 at 12:07 p.m., there was an unlabeled, open tube of skin barrier stored on the back of the toilet. The bathroom was shared by Residents # 14 and</p>			

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	<p>#71. During an interview at the time of the observation, Resident #14 indicated she did not know who the tube of cream belonged to.</p> <p>During an observation on 10/16/12 at 8:39 a.m., there was an uncovered bedpan and urinal stored on the rail in Resident #54's bathroom. During an interview at the time of the observation, LPN #11 indicated she was unsure why they were in the bathroom.</p> <p>During an observation on 10/16/12 at 9:06 a.m., Resident #27's bathroom, which she shares with Resident #5 and #23, had a raised toilet seat stored on the floor between the toilet and the wall. During an interview at the time of the observation, CNA #17 indicated Resident #5 will take the toilet riser off the toilet.</p> <p>During an observation on 10/16/12 at 1:59 p.m., Resident #101's bathroom had a wash basin stored on the floor in the bathroom, a plastic measuring container used to measure urine was uncovered and stored on the back of the toilet.</p> <p>During an interview on 10/22/12 at 3:20 p.m., the Staff Development Coordinator (SDC) indicated she</p>						

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	<p>does the inservice with staff for proper hygiene, proper handwashing techniques, and transmission modes of infection. She indicated she had not monitored for handwashing yet, and she had only began her position in the past month. She indicated handwashing is part of the yearly competency. She indicated she had not conducted a glucometer cleaning inservice.</p> <p>E) On 10/16/12, at 8:40 A.M., a soiled wash cloth was observed in the bathroom on the back on the toilet basin on top of wrapped, unused toilet paper. The bathroom was shared by Residents #53, #47, and #7.</p> <p>At 10/15/12 at 10:15 A.M., a urinal was observed on the hand rail in the bathroom unlabeled and not stored. A very small amount of light yellow fluid was observed in the corner of the urinal. The bathroom was shared by Resident #52, #76, #66 and #73.</p> <p>At 10/16/12 at 8:45 A.M., a urinal was observed on the hand rail in the bathroom unlabeled and not stored. The bathroom was shared by Residents #52, #76, #66 and #73.</p> <p>At 10/17/12 at 9:09 A.M., a urinal was</p>			

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	<p>observed on the hand rail in the bathroom unlabeled and not stored. The bathroom was shared by Residents #52, #76, #66 and #73.</p> <p>At 10/16/12 at 9:20 A.M., a urinal was observed in Resident #76's bottom drawer not covered. A very small amount of light yellow fluid was observed in the base of the urinal.</p> <p>On 10/16/12 at 1:00 P.M., a used, clear plastic graduated measuring cylinder was observed in Resident #45's closet, on the bottom shelf. The daughter indicated the cylinder was used to empty the resident's Foley catheter. The Foley catheter was discontinued on 9/24/12.</p> <p>An interview with the DON (Director of Nursing) on 10/19/12 at 3:15 P.M. indicated the urinals should be stored properly and the cylinder should have been removed and disposed of.</p> <p>An undated, facility policy, titled, "Offering & Removing the Bedpan", received from the Director of Nursing on 10/22/12 at 8:15 a.m., indicated, "...Clean the bedpan. Wipe dry with a clean paper towel. Discard paper towel in waste paper receptacle. Store the bedpan. Do not leave it in the bathroom or on the floor..."</p>			

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	<p>A policy was requested regarding how and where to store urinals and one was not received by end of survey 10/24/12.</p> <p>F) During observation on 10/15/12 at 12:23 pm, CNA #10 helped Resident # 59 to change his pants and assist to the East dining room. The CNA then immediately return to distributing food trays without hand hygiene.</p> <p>G) During observation on 10/19/12 at 8:45 a.m.: LPN # 7 was observed to prepare and administer medications touching Resident #26 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #31 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #20 without washing hands or using hand sanitizer before or after. LPN # 7 was observed to prepare and administer medications touching Resident #70 without washing hands or using hand sanitizer before or after.</p>			

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	<p>LPN # 7 was observed to prepare and administer medications touching Resident #10 without washing hands or using hand sanitizer before or after.</p> <p>LPN # 7 was observed to prepare and administer medications touching Resident #6 without washing hands or using hand sanitizer before or after.</p> <p>H) During observation on 10/19/12 at 10:11 a.m., LPN #7 was observed to prepare and administer medications, touching Resident # 33, including but not limited to: instilling eye drops, without washing hands or using hand sanitizer before or after, or using gloves.</p> <p>During interview of LPN #7 on 10/19/12 at 10:50 a.m., she indicated she washed her hands at the beginning of shift and she should have washed her hands when she touched the residents and picked up dropped items from the floor and she usually only washed her hands on medication pass when she touched a resident.</p> <p>Record review of facility policy revised 10/04, titled "POLICIES FOR MEDICATION ADMINISTRATION," received from the Director of Nursing (DoN) on 10/18/12 at 12:20 p.m.,</p>			

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	<p>indicated to follow the hand hygiene protocol before and after administration of medication.</p> <p>A facility policy, titled, "Hand Hygiene", dated 05/01/12, and received from the DoN as current, indicated, "...Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction..."</p> <p>Record review of Facility policy titled "EYE INSTILLATION," received from the DoN as current on 10/23/12 at 2:25 p.m., "...1. Wash hands thoroughly before beginning the procedure...6. Should both eyes require instillation, wash your hands before treating the second eye...9. Wash you (sic) hands thoroughly after completing the procedure..."</p> <p>3.1-52(b)(2)</p>			
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