

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2013
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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 4, 5, 6, 7, 8, 11, and 12, 2013</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Survey team: Regina Sanders, RN, TC Janelyn Kulik, RN (February 4, 2013) Kathleen Vargas, RN (February 4, 5, 6, 7, and 8, 2013) Heather Tuttle, RN (February 6, 7, and 8, 2013) Lara Richards, RN (February 6 and 7, 2013) Shannon Pietraszewski, RN (February 6, 7, and 8, 2013)</p> <p>Census bed type: SNF/NF: 57 Residential: 11 Total: 68</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 15 Total: 68</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Sample: Residential: 5 Residential Supplemental: 1</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 18, 2013, by Janelyn Kulik, RN.</p>			
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F0156 SS=A	<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 record review and interview, the facility failed to ensure Medicare Non-coverage letters were given in a timely manner for 2 of 3 residents reviewed for liability services of the 3 who met the criteria for liability services. (Residents #85 and #88)</p> <p>Findings include:</p> <p>On 2/7/13 at 10:59 a.m., the Medicare Non-coverage letter for Resident #88 was reviewed. The letter indicated Medicare A services would end on 9/30/12. The letter was signed by the resident on 10/1/12. Interview with the Corporate Business Office Manager, indicated the resident's family was verbally notified of Medicare A services ending prior to 10/1/12, however, there was no</p>	F0156	<p>F156 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Immediate action for the residents #85 and #88 is not applicable as the residents are no longer at the facility. 2) How the facility identified other residents: There were no outstanding notices upon follow up of this finding. 3) Measures put into place/ System changes: The system in place is MDS Coordinator completes the forms. The Business Office notifies the resident/responsible party and then mails letter as</p>	03/14/2013			

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	<p>documentation to indicate that had been completed.</p> <p>Continued interview with the Corporate Business Office Manager at this time, indicated when Resident #85 was discharged home on 10/7/12, there was no notification given related to how many remaining Medicare days the resident had and when services would end.</p> <p>3.1-4(a)</p>		<p>required. MDS and Business office received in-service training related to the process for Medicare Liability letters on the correct CMS forms. 4) How the corrective actions will be monitored: The Business Office Manager will maintain a tracking log to indicate compliance with this requirement. The administrator/designee will review each letter for one month; then weekly review thereafter. The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly times 6 months. 5) Date of compliance: March 14, 2013</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225				03/14/2013	

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	<p>interview, the facility failed to report an allegation of abuse timely to the Administrator of the facility, failed to protect the resident after an allegation had been voiced, and failed to notify the Indiana State Department of Health (ISDH) of the allegation of abuse, for 1 of 3 abuse allegations reviewed. (Resident #66)</p> <p>Findings include:</p> <p>During an interview on 02/04/13 at 2:24 p.m., Resident #66's family member indicated the resident had told them a CNA had "flung" Resident #66 onto the toilet and the resident's back had popped. The family member indicated she had reported this to the nurse (LPN #6) and the nurse (LPN #6) told her she would look into it. The family member indicated the nurse (LPN #6) had written a report up on the concern. They indicated it occurred about , "four weeks ago".</p> <p>During an interview with the DoN (Director of Nursing) on 02/06/13 at 9:31 a.m., she indicated on 12/20/12, (LPN #6) reported the resident had hit her back on the back of the toilet during care and there was no bruising. She indicated LPN #6 had said the CNA (CNA #2) had came to</p>		<p>F 225 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Res #66 was investigated and interviews obtained with no findings of abuse or neglect. Resident interviewed by Social Services with no indications of psychosocial harm. This was a past event that cannot be remedied. 2) How the facility identified other residents: A full house audit was done on alert and oriented residents to interview if there were any allegations of abuse or neglect. Abuse allegations in last 30 days were reviewed and no other issues were identified. 3) Measures put into place / System changes: Facility staff were re-educated regarding immediate reporting of all abuse allegations to the Administrator. Administrator will review and oversee all investigations including written and verbal statements related to allegations of abuse as they</p>				

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	<p>LPN #6 and reported the incident.</p> <p>During an interview with LPN #6 on 02/04/13 at 10:20 a.m., she indicated Resident #66's family had reported the concern to her. She indicated she interviewed CNA #2 and the CNA told her what happened. LPN #6 indicated the family had said the CNA had "tossed" the resident onto the toilet and she hit her back. LPN #6 indicated Resident #66 was confused and upset and the family was upset. She indicated the Administrator and the DoN were in the building at the time the concern was voiced and she had given her investigation to the Administrator. LPN #6 indicated the Administrator was given the paper with the family's concern written on it. LPN #6 indicated the Administrator informed her, she should have notified the Administrator immediately, when it happened.</p> <p>During an interview on 02/06/13 at 10:47 a.m., the Administrator indicated the allegation had not been reported to him, and the allegation had not been reported to the ISDH. He indicated he did not have a report from LPN #6. The DoN indicated if this is how the allegation was reported to LPN #6, then LPN #6 did not follow the facility's policy for</p>		<p>arise to ensure that investigations are completed thoroughly and allegations are reported immediately. 4) How the corrective actions will be monitored: A Log will be kept daily by Administrator/Designee of all concerns/allegations reported by staff, residents or family. Results of audits will be reviewed in the monthly Quality Assurance meeting monthly x 6 months. 5) Responsible Person Administrator/Designee 6) Date of Compliance March 14, 2013</p> <p>QA AUDITING TOOL QUALITY ASSURANCE AUDIT TYPE OF AUDIT: F 225 and F 226 ABUSE REPORTING/ INVESTIGATIONS</p> <p>RESIDENT NAME DATE & TIME ALLEGATION REPORTED TO STAFF NAME OF STAFF ALLEGATION WAS REPORTED TO DATE & TIME HFA NOTIFIED OF ALLEGATION NATURE OF ALLEGATION DATE & TIME REPORTED TO ISDH STAFF INTERVIEWS COMPLETED TIMELY RESIDENT INTERVIEWS COMPLETED TIMELY CORRECTIVE ACTION TAKEN</p>		

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	<p>Abuse, because she did not report it to the Administrator immediately.</p> <p>A typed note, dated 12/21/12, received from the DoN on 02/04/12 at 11:30 a.m., indicated, "(LPN #6's name) reported that when (Resident #66) was sitting on the toilet during care at 1045 (10:45 a.m.) she was sitting on the toilet seat and lost balance bumping the back of the toilet. The CNA was present and assisted her back to a comfortable position on the toilet. She then completed care and the nurse was notified..."</p> <p>A timecard, dated 12/20/12, indicated CNA #2 continued to work on the unit from 5:58 a.m. to 2:07 p.m., on 12/20/12 and from 9:53 p.m. to 12:12 p.m., on 12/21/12.</p> <p>During an interview with CNA #2 on 02/12/13 at 8:55 a.m., CNA #2 indicated she had taken the resident to the bathroom and the toilet seat had moved and made a noise, which scared the resident. She indicated the resident had not hit her back on the toilet. CNA #2 indicated she did not know anything about the allegations until the resident's daughter had voiced the concern to LPN #6. She indicated LPN #6 wrote</p>		<p>RELATED TAGS: F225, F226</p> <p>AUDITOR SIGNATURE _____</p> <p>DATE: _____</p>	
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	<p>out a report. CNA #2 indicated she had not been taken off the hall after the concern was made by the family.</p> <p>Resident #66's record was reviewed on 02/06/13 at 11:36 a.m. The resident's diagnoses included, but were not limited to , dementia and hypertension.</p> <p>The Resident's Admission Minimum Data Set Assessment, dated 08/03/12, indicated the resident's cognition was impaired.</p> <p>3.1-28(c) 3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's abuse policy, related to protection of residents after an allegation of abuse, reporting allegations of abuse to the Administrator immediately, and reporting the allegation to the Indiana State Department of Health (ISDH) for 1 of 3 allegations reviewed for abuse allegations. (Resident #66)</p> <p>Findings include: During an interview on 02/04/13 at 2:24 p.m., Resident #66's family member indicated the resident had told them a CNA had "flung" Resident #66 onto the toilet and the resident's back had popped. The family member indicated she had reported this to the nurse (LPN #6) and the nurse (LPN #6) told her she would look into it. The family member indicated the nurse (LPN #6) had written a report up on the concern. They indicated it occurred about ,</p>	F0226	<p>F 226 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Res #66 was investigated and interviews obtained with no findings of abuse or neglect. Resident interviewed by Social Services with no indications of psychosocial harm. This was a past event that cannot be remedied. 2) How the facility identified other residents: A full house audit was done on alert and oriented residents to interview if there were any allegations of abuse or neglect. Abuse allegations in last 30 days were reviewed and no other issues were identified. 3) Measures put into place / System changes: Facility staff were re-educated regarding immediate reporting of all abuse allegations to the Administrator. Administrator will</p>	03/14/2013

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	<p>"four weeks ago".</p> <p>During an interview with the DoN (Director of Nursing) on 02/06/13 at 9:31 a.m., she indicated on 12/20/12, (LPN #6) reported the resident had hit her back on the back of the toilet during care and there was no bruising. She indicated LPN #6 had said the CNA (CNA #2) had came to LPN #6 and reported the incident.</p> <p>During an interview with LPN #6 on 02/04/13 at 10:20 a.m., she indicated Resident #66's family had reported the concern to her. She indicated she interviewed CNA #2 and the CNA told her what happened. LPN #6 indicated the family had said the CNA had "tossed" the resident onto the toilet and she hit her back. LPN #6 indicated Resident #66 was confused and upset and the family was upset. She indicated the Administrator and the DoN were in the building at the time the concern was voiced and she had given her investigation to the Administrator. LPN #6 indicated the Administrator was given the paper with the family's concern written on it. LPN #6 indicated the Administrator informed her, she should have notified the Administrator immediately, when it happened.</p>		<p>review and oversee all investigations including written and verbal statements related to allegations of abuse as they arise to ensure that investigations are completed thoroughly and allegations are reported immediately. 4) How the corrective actions will be monitored: A Log will be kept daily by Administrator/Designee of all concerns/allegations reported by staff, residents or family. Results of audits will be reviewed in the monthly Quality Assurance meeting monthly x 6 months. 5) Responsible Person Administrator/Designee 6) Date of Compliance March 14, 2013 QA AUDITING TOOLQUALITY ASSURANCE AUDIT TYPE OF AUDIT: F 225 and F 226 ABUSE REPORTING/ INVESTIGATIONS RESIDENT NAME DATE & TIME ALLEGATION REPORTED TO STAFF NAME OF STAFF ALLEGATION WAS REPORTED TO DATE & TIME HFA NOTIFIED OF ALLEGATION NATURE OF ALLEGATION DATE & TIME REPORTED TO ISDH STAFF INTERVIEWS COMPLETED TIMELY RESIDENT INTERVIEWS COMPLETED TIMELY CORRECTIVE ACTION TAKEN RELATED TAGS: F225, F226 AUDITOR SIGNATURE _____</p>		

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	<p>During an interview on 02/06/13 at 10:47 a.m., the Administrator indicated the allegation had not been reported to him and the allegation had not been reported to the ISDH. He indicated he did not have a report from LPN #6. The DoN indicated if this is how the allegation was reported to LPN #6, then LPN #6 did not follow the facility's policy for Abuse, because she did not report it to the Administrator immediately.</p> <p>A typed note, dated 12/21/12, received from the DoN on 02/04/12 at 11:30 a.m., indicated, "(LPN #6's name) reported that when (Resident #66) was sitting on the toilet during care at 1045 (10:45 a.m.) she was sitting on the toilet seat and lost balance bumping the back of the toilet. The CNA was present and assisted her back to a comfortable position on the toilet. She then completed care and the nurse was notified..."</p> <p>A timecard, dated 12/20/12, indicated CNA #2 continued to work on the unit from 5:58 a.m. to 2:07 p.m., on 12/20/12 and from 9:53 p.m. to 12:12 p.m., on 12/21/12.</p> <p>During an interview with CNA #2 on 02/12/13 at 8:55 a.m., CNA #2</p>		<p>_____</p> <p>DATE: _____</p>	
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	<p>indicated she had taken the resident to the bathroom and the toilet seat had moved and made a noise, which scared the resident. She indicated the resident had not hit her back on the toilet. CNA #2 indicated she did not know anything about the allegations until the resident's daughter had voiced the concern to LPN #6. She indicated LPN #6 wrote out a report. CNA #2 indicated she had not been taken off the hall after the concern was made by the family.</p> <p>A facility policy, dated 10/05, and received as current from the Administrator, indicated, "...8. The facility will ensure that all allegations of mistreatment, neglect or abuse...are reported immediately to the Administrator of the facility and to other officials in accordance with state law...The Administrator and/or other officials shall notify ISDH in accordance with the ISDH guidelines...If resident sustains injury by an employee or employee is a suspected perpetrator: i. Remove the employee immediately. ii. Staff is to notify immediate supervisor and he or she must conduct interview with the employee and resident. iii. Employee must be sent home (suspended) immediately pending outcome of final investigation..."</p>			

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	3.1-28(a)			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to waiting to enter a resident's room after knocking and for addressing residents as "Honey and/or Sweetie" for 2 of 3 residents reviewed for dignity and for 1 additional resident observed of the 7 residents who met the criteria for dignity. (Residents #6, #51 and #61)</p> <p>Findings include:</p> <p>1. On 2/4/13 at 12:29 p.m., Resident #61 was observed sitting at the table in the dining room. At that time, staff were observed calling the resident "Honey" rather than using her real name. There were other residents sitting at the same table.</p> <p>On 2/4/13 from 12:25 to 12:45 p.m. CNA #1 was observed calling Resident #61 "Honey".</p> <p>On 2/5/13 at 8:00 a.m. CNA #1 was observed assisting Resident #61 to</p>	F0241	<p>R 0241 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Medication Error Report was completed on QMA #3 for Resident #9 and MD notified. Order obtained to check Valproic Acid level which came back indicating within therapeutic level. No harm occurred to resident. Resident #2, MD notified for order to discontinue Zyrtec. Zyrtec was not administered so duplication of medication administration did not occur. No harm to resident. 2) How the facility identified other residents: Medication Administration Records and medications of all residents were reviewed since 02-01-13 for any medication parameters not being followed per facility protocol; as well as medications discontinued</p>	03/14/2013			

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	<p>bed. At that time, she called the resident "Honey" during the transfer.</p> <p>On 2/6/12 at 12:00 p.m., QMA #1 was observed standing by the medication cart. She then was observed passing medications to Resident #61. At that time, she was trying to get the resident to open her mouth. She then stated to the resident "You need to spit out your gum Honey." It's time to take you medicine Honey, this will help your tummy."</p> <p>The record for Resident #61 was reviewed on 2/6/13 at 1:33 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbances, psychosis, and depressive disorder</p> <p>Review of the current plan of care dated 1/2/13, indicated cognitive loss, the resident had short term memory and long term memory loss as evidenced by a BIMS (brief interview for mental status) score of 3 which indicate cognitive impairment. The Nursing approaches were to call the resident by her name frequently.</p> <p>Interview with CNA #1 on 2/7/13 at 10:19 a.m., indicated she was aware she was not suppose to call the resident's sweetie and honey. She</p>		<p>without physicians' order and physicians notified as indicated.</p> <p>3) Measures put into place / System changes: In-service training held for all licensed nursing staff including QMA's on obtaining vitals as ordered for medications and if vitals are within parameters that medications need to be held, QMA will obtain direction from licensed nurse on holding medication. When administration of a PRN medication by a QMA, permission will be documented including nurse's name. QMAs may only do follow up documentation on a PRN when an assessment is not required such as when the resident is able to state the effectiveness of the medication and an assessment is not required. All licensed nursing staff were in-serviced on correct dosing of liquid medications by use of syringe to draw up correct dose. 4) How the corrective actions will be monitored: Pharmacy audit will be conducted monthly and any discrepancies will be noted on audit. DON/Designee will audit QMA medication administration entries 3 times a week for PRN administration and follow-up documentation. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months.</p> <p>5) Responsible Person DON /Designee</p>		

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	<p>further indicated she was unaware the resident's care plan indicated to call her by her name.</p> <p>2. On 2/5/13 at 12:30 p.m., RN #1 was observed doing a glucometer for Resident #51. At that time, RN #1 addressed the resident as "Sweetie" rather than her name.</p> <p>3. On 2/5/13 at 9:05 a.m., the Resident Interview was initiated with Resident #6. The interview was conducted in the resident's room. The door was closed to the resident's room to maintain confidentiality.</p> <p>On 2/5/13 at 9:13 a.m., during the Resident Interview, CNA #3 knocked on the resident's closed door. She did not wait for a response from the resident. She entered the resident's room.</p> <p>On 2/5/13 at 9:19 a.m., during the Resident Interview with Resident #6, LPN #1 knocked on the door. She did not wait for the resident to respond, she entered the room and indicated she was looking for the resident's roommate.</p> <p>The record for Resident #6 was reviewed on 2/6/13 at 8:00 a.m. The Annual Minimum Data Set (MDS) assessment, dated 11/21/12,</p>						

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	<p>indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14, which indicated she was cognitively intact. The MDS indicated the resident had clear speech.</p> <p>Interview with the Social Service Director on 2/7/13 at 2:10 p.m., indicated staff were to knock on the resident's door. They were to wait for the resident to respond and give permission to enter the resident's room. She indicated Resident #6 was alert and oriented and was able to respond to the staff knocking on her door. She also indicated the resident was able to give permission to enter her room.</p> <p>3.1-3(t)</p>			

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's choice was honored related to bathing for 2 of 3 resident's reviewed for choices of the five residents who met the criteria for choices. (Residents #1 & #32)</p> <p>Findings include:</p> <p>1. Interview with Resident #32 on 2/5/13 at 8:48 a.m., indicated the resident would like a shower everyday, however she was told by staff there were too many people that lived here, therefore, she only gets a shower two times a week.</p> <p>On 2/6/13 at 2:15 p.m., the resident indicated the Social Service Director had interviewed her and asked her what her preferences were for bathing and the number of times a week she wished to receive a shower. She indicated she told staff she would like a shower every other day.</p>	F0242	<p>F242 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Residents #1 and #32 were interviewed on preferences of bathing and frequency of bathing. Preferences were noted on resident care sheets. 2) How the facility identified other residents: A full house audit of resident preferences on type of bathing and frequency was completed on all alert and oriented residents. 3) Measures put into place / System changes: Preferences were updated on resident care sheets. Resident Choice Questionnaire was developed and placed in admission packet and also be utilized during subsequent care plan meetings to</p>	03/14/2013			

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	<p>Interview with LPN #1 on 2/6/13 at 2:21 p.m., indicated showers were given during the day shift and evening shift. She further indicated Resident #32's shower days were on Wednesdays and Saturdays during the day shift.</p> <p>Review of the resident care sheet on 2/6/13 at 2:25 p.m., indicated there was no information regarding the resident's preferences for the number of times a week she would like a shower.</p> <p>Interview with the Director of Nursing (DoN) on 2/6/13, at 2:30 p.m., indicated she keeps the care cards up to date and prints them off for the CNA's to use. She further indicated she had talked to the resident everyday and she had not ever expressed that she wanted to take a shower more than two times a week. The DoN also indicated that she had not asked the resident that question before either.</p> <p>Interview with the Social Service Director on 2/6/13 at 2:40 p.m., indicated she had just interviewed the resident earlier in the day regarding her preference for the number of times a week she takes a shower.</p>		<p>remain current with residents' choice and preferences. A capitol expense request for a new bathing tub was submitted to corporate for approval. 4) How the corrective actions will be monitored: The completed Questionnaire on admission and subsequent care plans will be given to Medical Records to update bathing list and a copy to DON/Designee to audit resident care sheets on resident preferences. Updates will be done upon receipt of completed questionnaire 3 times weekly. Resident preferences will be discussed in morning clinical meetings. Results of audits will be reviewed in the monthly Quality Assurance meeting monthly x 6 months. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013 AUDIT TOOL/QUESTIONNAIRE REF 242 CHOICES – PERSONAL PREFERENCES RESIDENT NAME: _____ DATE: _____ INTERVIEWER'S NAME: _____ _____ _____ 1. What is your normal time to get up in the morning? _____ What time would you like to get up in the morning</p>		

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	<p>She indicated they have done a house wide audit since it was brought to their attention earlier in the day regarding the resident's preferences not being met for bathing.</p> <p>The record for Resident #32 was reviewed on 2/6/13 at 12:20 p.m. The resident was admitted to the facility on 12/7/12. The resident's diagnoses included, but were not limited to, muscle weakness, depressive disorder, high blood pressure, hypothyroidism, osteoarthritis, manic disorder and schizo affective disorder.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 12/14/12, indicated the resident was alert and oriented and it was very important to choose between a tub bath, shower or bed bath.</p>		<p>while at our facility?</p> <p>_____</p> <p>2. What time do you normally go to bed at night?</p> <p>_____</p> <p>_____ What time would you like to go to bed while at our facility?</p> <p>_____</p> <p>3. Do you have a preference of a tub bath, shower or bed bath?</p> <p>_____ Are alternatives acceptable to you if your first choice is not available?</p> <p>_____ What is an acceptable alternative?</p> <p>_____</p> <p>_____ Our facility schedule and preference is: showers/2 times per week and personal care provided daily and as needed.</p> <p>Is this schedule acceptable to you or do you prefer a different schedule such as: 3 times per week, 4 times per week, daily etc?</p> <p>_____</p> <p>_____ Do you have a preference of days or times you are bathed?</p> <p>_____ YES</p> <p>_____ NO If you have a preference please indicate the days/times of preference:</p> <p>_____</p> <p>_____</p>	

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	<p>2. Resident #1 was interviewed on 2/05/13 at 9:54 a.m. The resident indicated she did not get to choose if she had a shower, a tub bath or a sponge bath. She indicated she would like to take tub baths. She also indicated there were no bath tubs in the facility.</p> <p>Resident #1 resided on the South Unit. The South Unit Central Bathing Room was observed on 2/6/13 at 8:40 a.m. There was no bath tub in the South Unit Central Bathing Room.</p> <p>The North Unit Central Bathing Room was observed on 2/6/13 at 8:45 a.m. There was a bath tub in the room. There was a lift seat on the bath tub.</p> <p>The record for Resident #1 was reviewed on 2/6/13 at 9:19 a.m. The Annual Minimum Data Set (MDS) assessment dated 6/5/12, indicated it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>On 2/6/13 at 9:53 a.m., CNA #4 was interviewed. She indicated she had worked in the facility for 6 years. She indicated she worked most often on the North Unit. She indicated that she</p>			

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	<p>had never used the bath tub in the North Unit Central Bathing Room. She did not think the bath tub was functional.</p> <p>On 2/6/13 at 9:58 a.m., CNA #5 was interviewed. She indicated that she had taken care of Resident #1 in the past. She indicated she had assisted the resident with showers. She indicated she had never assisted Resident #1 with a tub bath. She indicated she had never seen the bath tub in the facility used.</p> <p>Interview with the Director of Nursing on 2/6/13 at 3:10 p.m., indicated she had been in the building since November 2012. To her knowledge the bath tub had not been used in that time. She indicated she thought the lift on the tub was not functioning and that was the reason the bath tub was not used.</p> <p>On 2/7/13 at 8:00 a.m., the Maintenance Supervisor was interviewed. He indicated the bath tub appeared to be functional. He indicated that he had not received a work order for any repairs for the tub. He indicated he has worked at the facility for 5 years. He indicated he was planning on having a representative for the bath tub come</p>						

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	and inspect the tub and the lift prior to using it for residents. 3.1-3(u)(3)				

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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F0278 SS=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate related to nutrition, level two assessments, dental, infections, and rehabilitation for 5 of 32 residents reviewed for MDS accuracy. (Residents #1, #25,</p>	F0278	<p>F 278 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>	03/14/2013

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	<p>#70, #82, and #88)</p> <p>Findings include:</p> <p>1. On 2/7/13 at 10:20 a.m., CNA #2 was asked to measure Resident #82's height. At that time, the resident stood against the wall and the CNA proceeded to obtain his height. The resident's height was 64 inches (five foot four inches tall).</p> <p>The record for Resident #82 was reviewed on 2/6/13 at 1:00 p.m. The resident was admitted to the facility on 8/4/12. The resident's diagnoses included, but were not limited to, congestive heart failure, chronic airway obstruction, and hyperlipidemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 11/27/12, indicated the resident was alert and oriented. He had no swallowing or chewing problems. The resident weighed 144 pounds and his height was recorded at 72 inches.</p> <p>Review of the vital signs record taken on 8/12/12 indicated the resident's height was obtained while the resident was lying down. The resident's height was recorded at 72 inches (six feet tall).</p>		<p>1) Immediate actions taken for those residents identified: Regarding residents #'s 1, 25, 70, 82, and 88, MDS Assessments were corrected. 2) How the facility identified other residents: Audit was conducted for accuracy of height, level II's, level of transfer ability, assessments, diagnoses of all comprehensive assessments completed within the last 30 days. 3) Measures put into place / System changes: The Corporate MDS Consultant provided training on the completion of comprehensive and ancillary MDS assessments. DON provided in-service training to nursing staff on correct measuring technique of height and accurate completion of resident assessments. All new admissions/re-admissions will be communicated during morning meeting with the interdisciplinary team. 4) How the corrective actions will be monitored: An audit will be completed on at least 3 MDS assessments weekly for accuracy. Results of audits will be reviewed in the monthly Quality Assurance meeting monthly x 6 months. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013</p>		

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	<p>Interview with LPN #1 on 2/7/13 at 2:00 p.m., indicated the nurse who admits the resident was responsible for obtaining the resident's height and recording it in the computer.</p> <p>Interview with the MDS Coordinator on 2/7/13 at 2:16 p.m., indicated she was unaware the resident's height was inaccurate.</p> <p>2. The record for Resident #1 was reviewed on 2/6/13 at 9:19 a.m. The resident had diagnoses that included, but were not limited to, depression, anxiety, personality changes and schizo-affective disorder.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 6/5/12, was reviewed. The section that indicated, "Is the resident currently considered by the state level II PASRR (PreAdmission Screening for Resident Review) process to have a serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?" The MDS was coded, "no."</p> <p>The state form titled, "State of Indiana Certification of PASRR /MI(Mentally III) PreAdmission Screening Determination" dated 8/8/11, was</p>						

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	<p>reviewed. It indicated the review was for Resident #1, the applicant. It indicated, "Level II Mental Health Determination: The Applicant/Resident is mentally Ill."</p> <p>On 2/6/13 at 9:46 a.m., the Social Service Director was interviewed. She indicated the Annual MDS assessment dated 6/5/12, was inaccurately coded. She indicated the MDS should have been coded that the resident had a serious mental illness that required PreAdmission Screening and Resident Review.</p> <p>3. The closed record for Resident #88 was reviewed on 2/7/13 at 2:14 p.m. The resident had diagnoses that included, but were not limited to, altered mental status and osteoarthritis.</p> <p>The 30 day Minimum Data Set (MDS) assessment with an ARD (Assessment Reference Date) of 9/13/12, was reviewed. It indicated the resident's transfer ability was coded as 3/2, which indicated the resident required extensive assistance with one person physical assist.</p> <p>Review of the ADL (activities of daily living) flow record from 9/7/12</p>						

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	<p>through 9/13/12, indicated the resident required extensive assistance with transfers on two occasions. The resident required supervision or limited assistance on the other occasions.</p> <p>Interview with the MDS Coordinator on 2/8/13 at 10:50 a.m., indicated the 30 day MDS was inaccurately coded. She indicated the MDS should have been coded 2/2, which indicated the resident required limited assistance with one person physical assist.</p> <p>4. Resident #25's record was reviewed on 2/7/13 at 11:30 a.m. Resident #25's diagnoses included, but were not limited to, hypertension, anxiety, and Alzheimer's disease.</p> <p>Review of an Admission Nursing Assessment dated 5/9/12, indicated the resident had her own teeth, with a lower partial, and denture to the top. The assessment indicated the resident did have broken, missing and/or carious (tooth decay) teeth.</p> <p>Review of an Admission 5 day MDS (Minimum Data Set) Assessment dated 5/9/12, indicated the resident did not have broken or loosely fitting full or partial dentures, no natural teeth or tooth fragments, abnormal mouth tissue, obvious or likely cavity</p>						

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	<p>or broken natural teeth.</p> <p>Review of an Oral Dental Evaluation performed by the facility on 8/10/12 at 4:08 p.m., indicated the resident did have her own teeth and did not have any broken or missing teeth [sic]. The evaluation indicated the resident did not have any dentures or partials [sic].</p> <p>Review of the quarterly MDS dated 11/12/12 indicated the resident did not have [sic] broken or loosely fitting full or partial denture.</p> <p>Review of an Oral Dental Evaluation performed by the facility on 11/16/12 at 11:43 p.m., indicated the resident did have her own teeth and she did have broken and/or missing teeth. The evaluation indicated the resident did not have upper dentures but did have lower partials [sic]. There was a notation of the resident having cavities to her lower mandible (lower teeth).</p> <p>A dental exam on 1/24/13, indicated the resident's appliance was fair, the current denture was fair and the fit was fair. The treatment plan indicated all other teeth were broken.</p> <p>A interview with Resident #25 on</p>				

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	<p>2/5/13 at 9:33 a.m., indicated she did have some broken teeth on the bottom gum.</p> <p>An interview with the MDS Coordinator on 2/7/13 at 1:00 p.m., indicated she had never seen the resident with dentures or a partial and did not indicate where she retrieved her information for the MDS assessment. At 1:30 p.m., the MDS Coordinator indicated she had checked the resident's oral cavity and the resident did have a full upper denture and a lower partial.</p> <p>5. Resident #70's record was reviewed on 2/7/13 at 12:18 p.m. Resident 70's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's, and Dementia.</p> <p>A urinalysis, which was obtained on 10/22/12, indicated the resident tested positive for protein, blood, white blood cells (infection) and bacteria which indicated the resident had an urinary tract infection. Bactrim DS (antibiotic) was ordered twice a day for 10 days.</p> <p>Review of a 14 Day MDS (Minimum Data Set) assessment dated 11/6/12, indicated the resident had not been treated for a UTI in the last 30 days.</p>						

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	<p>An interview with the MDS Coordinator 2/7/13 at 1:00 p.m., indicated she coded the resident as being on an antibiotic, but had overlooked the coding for an UTI.</p> <p>3.1-31(c)(1) 3.1-31(c)(9)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to follow physician's orders and care plans, related to a x-ray, side rails, and skin checks for 2 of 32 residents reviewed for physician's orders and care plans. (Residents #10 and #96)</p> <p>Findings include:</p> <p>1. Resident #10's record was reviewed on 02/07/13 at 8:15 a.m. This diagnoses included, but were not limited to, chronic kidney disease and diabetes mellitus.</p> <p>A. During an observation on 02/04/2013 at 03:17 p.m., there were four side rails in an up position on Resident #10's bed.</p> <p>During an observation on 02/06/13 at 8:30 a.m., there were four side rails in an up position on Resident #10's bed.</p> <p>During an observation on 2/7/13 at 9:24 a.m., Resident #10 was in bed and there were four side rails in an up position.</p>	F0282	<p>F 282 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. The facility does ensure that physician orders are communicated and followed and resident care is provided based on resident need. 1) Immediate actions taken for those residents identified: Resident #10 has a rental therapeutic bed and rental company notified to come and remove the lower rails as are not needed for resident. Resident #10 had initial non-pressure skin assessment performed and will have dry skin patch monitored until area is resolved. MD/Family notification made. Resident #96 had repeat CXR which indicated no acute changes, reported to MD. No harm resulted to resident. A med error was completed. 2) How the facility identified other residents: All resident beds assessed for any rails other than</p>	03/14/2013			

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	<p>A Side Rail Evaluation dated 1/10/13, indicated side rails were present and half side rails were used.</p> <p>A care plan, initially dated 02/15/11 and revised on 10/18/12, indicated the resident required assistance with activities of daily living. The interventions included to use half bed rails as an enabler.</p> <p>During an interview on 02/07/13 at 9:33 a.m., the ADoN (Assistant Director of Nursing) indicated the resident should never have all four side rails up. She indicated no one should have all four side rails up.</p> <p>B. During an observation on 02/04/2013 at 03:15 p.m., Resident #10 had a circular area which was pink with a scab on the back of his left hand.</p> <p>During an interview on 02/07/13 at 9:25 a.m., the ADoN indicated the area on the back of Resident #10's hand looked like it was, "scabbed over".</p> <p>During an interview on 02/07/13 at 9:31 a.m., the ADoN indicated she could not find treatment orders or documentation for the area on the</p>		<p>upper half rails and none noted. A full house skin sweep will be completed and any skin issues will have an assessment completed and reported to MD/POA/Wound Nurse. Last seven days of progress notes was reviewed for any orders missed. No other residents were identified. 3) Measures put into place/System changes: In-service all nursing staff that the only side rails that are to be utilized are half rails and are to be utilized per care plan and placed on resident care sheets. In-service nursing staff that all skin issues must be documented on skin assessments and reported to MD/POA/Wound Nurse and monitored weekly until resolved. DON/Designee will randomly audit 3 weekly skin checks per week for any skin issues or concerns. In-service all licensed nursing staff to review MD progress notes for orders to be processed. All MD progress notes will be reviewed in Morning Clinical Meeting to audit for any orders. New medication orders will be audited at least twice weekly to ensure that an appropriate diagnosis and/or lab monitoring are present for use of medications as recommended. 4) How the Corrective Actions will be monitored: All residents with siderails will be audited for</p>				

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	<p>back of the resident's left hand.</p> <p>The 01/30/13 and 01/23/13 weekly skin assessments indicated the resident had no skin tears.</p> <p>The care plan, dated 12/06/12, indicated the resident was at risk for developing pressure ulcers. The interventions included to complete skin assessments weekly and as needed.</p> <p>During an interview on 2/7/13 at 10:37 a.m., the Wound nurse indicated the area was a dry spot on the back of his left hand. She indicated the resident has had it off and on, "forever". She indicated the nurses' should have documented the area in the progress notes or on the skin assessments when the area appears. She indicated the nurse had just told her about the area.</p> <p>2. Resident #96's record was reviewed on 02/06/13 at 1:17 p.m. The resident's diagnoses included, but were not limited to, fractured humerous, congestive heart failure, hypokalemia, and vascular dementia.</p> <p>A physician's progress note, dated 01/16/13, indicated to obtain another x-ray (no area listed).</p>		<p>appropriate type monthly and audit will be reviewed in Monthly Quality Assurance meeting x 6 months. Audit findings will be discussed in Monthly QA meeting x 6 months. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013</p>		

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	<p>There was a lack of documentation in the record to indicate the resident had another x-ray completed.</p> <p>During an interview on 02/06/13 at 2:55 p.m., the Medical Records Nurse indicated she had no record of an x-ray being completed.</p> <p>The record indicated a chest x-ray had been obtained on 02/06/13 at 5:14 p.m.</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 observation, record review and interview, the facility failed to ensure residents received treatments for a skin tear and an open/dry skin area for 2 of 4 residents observed with skin conditions. (Residents #10 and #34)</p> <p>Findings include:</p> <p>1. Resident #10's record was reviewed on 02/07/13 at 8:15 a.m. This diagnoses included, but were not limited to, chronic kidney disease and diabetes mellitus.</p> <p>During an observation on 02/04/2013 at 03:15 p.m., Resident #10 had a circular area which was pink with a scab on the back of his left hand.</p> <p>During an interview on 02/07/13 at 9:25 a.m., the ADoN indicated the area on the back of Resident #10's hand looked like it was, "scabbed over".</p>	F0309	<p>F 309 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Resident #10 had assessment performed by the wound nurse and dry patch was reported to the MD. Weekly monitoring will be done until resolved. Resident #34 had assessment of skin tear performed by wound nurse and will be monitored weekly until resolved. 2) How the facility identified other residents: A full house skin sweep will be completed and any skin issues will have an assessment completed and reported to MD/POA. 3) Measures put into place / System changes: In-service nursing staff that all skin issues must be documented on skin</p>	03/14/2013	

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	<p>During an interview on 02/07/13 at 9:31 a.m., the ADoN indicated she could not find treatment orders or documentation for the area on the back of the resident's left hand to indicate when the first occurred .</p> <p>During an interview on 2/7/13 at 10:37 a.m., the Wound nurse indicated the area was a dry spot on the back of his left hand. She indicated the resident has had it off and on, "forever". She indicated the nurse had just told her about the area.</p> <p>2. On 2/5/13 at 11:40 a.m., Resident #34 was observed with a skin tear on the back of his left hand.</p> <p>On 2/6/13 at 2:10 a.m., Resident #34 was observed with a dried skin tear on the back of his left hand.</p> <p>On 2/7/13 at 9:00 a.m., Resident #34 was observed with a dried skin tear on the back of his left hand that was open to air.</p> <p>Resident #34's record was reviewed on 2/6/12 at 2:14 p.m. Resident #34's diagnoses included, but were not limited to, peripheral vascular disease, Alzheimer/dementia, and lower limb amputations (bilaterally).</p>		<p>assessments and reported to MD/POA and Wound Nurse. All non-pressure skin conditions must be monitored and documented weekly until resolved. 4) How the corrective actions will be monitored: 3 random resident skin assessments will be completed by wound nurse to assess for any skin issues. Results of audits will be reviewed in the monthly Quality Assurance meeting monthly x 6. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013</p>				

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	<p>A Weekly Skin Assessment on 2/4/13 at 10:40 a.m., indicated the resident did not have a skin tear, bruise, or any open areas.</p> <p>Record review on 2/7/13 at 9:20 a.m., did not indicate a skin assessment was completed nor was there nursing documentation related to the dried skin tear.</p> <p>Interview with LPN #3 on 2/6/13 at 3:00 p.m., indicated she was not aware of the skin tear on the back of the resident's left hand. LPN #3 indicated she would assess the area.</p> <p>Interview with Wound Care Nurse on 2/7/13 at 1:20 p.m., indicated the staff were usually good at letting her know about any skin issues. The Wound Care Nurse indicated she did observe the area on the back of the left hand and it had been assessed and documented.</p> <p>A facility policy, dated 10/10, titled, "Skin Condition and Pressure Ulcer Assessment", received as current from the RN Nurse Consultant, indicated, "...1. All residents known or not known to have skin problems, will have a body check/assessment by a licensed nurse at least weekly...Each resident will be observed for skin</p>			

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	breakdown or problems on their scheduled shower/bath days by the CNAs. Changes are to be promptly reported to a licensed nurse who will then perform a complete assessment...Licensed Nurse will notify physician and family...Physician-ordered treatments will be documented on the Treatment Administration Record..." 3.1-37(a)			
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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 interviews, the facility failed to ensure each resident was free from unnecessary medications related to the lack of indications for the use of each medication and for the lack of monitoring laboratory levels of medications related to the use of potassium supplements, for 2 of 10 residents reviewed for unnecessary medications. (Resident #45 and Resident #96)</p>	F0329	<p>F 329 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Resident #45 has physician indication in progress note of history of hypokalemia. This has been added to current</p>	03/14/2013			

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	<p>Findings include:</p> <p>1. The record for Resident #45 was reviewed on 2/6/13 at 11:46 a.m. The resident had diagnoses that included, but were not limited to, vascular dementia, hypothyroidism and anxiety.</p> <p>The resident was admitted to the facility on 12/1/12. The current Physician Orders were reviewed. There was a Physician Order dated 12/1/12, that indicated, "Potassium chloride (a supplement of essential body electrolytes) Extended Release 10 MEQ (milliequivalents) oral (by mouth) two times a day."</p> <p>Review of the resident's diagnoses indicated there was no evidence of a diagnosis for the use of the potassium supplement. Review of the resident's current medication orders indicated there was no evidence that the resident was receiving a medication that caused a depletion of potassium from the body.</p> <p>There was a Physician Progress note dated 12/1/12, that included orders that indicated, "BMP (basic metabolic profile a laboratory test which includes a potassium level), TSH (thyroid stimulating Hormone a</p>		<p>care plan. Current lab work was communicated to the MD with residents' electrolytes within normal range guidelines with supplemental potassium use. Resident #96 had labs drawn with results communicated to the MD. No harm was done to the resident. 2) How the facility identified other residents: Last seven days of progress notes were reviewed for any orders missed. Lab audit completed to identify if any labs have been missed. No other residents were identified. 3) Measures put into place / System changes: Licensed staff will be re-educated on obtaining appropriate diagnosis for medication use and medications that require lab monitoring. Licensed staff will be re-educated on reviewing written physician progress notes for any orders to be input into electronic records. New medication orders will be audited at least twice weekly to ensure that an appropriate diagnosis and/or lab monitoring are present for use of medications as recommended. 4) How the corrective actions will be monitored: Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013</p>				

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	<p>laboratory test to assess thyroid function) and Free T4 (a laboratory test to assess thyroid function)" were to be obtained.</p> <p>Review of the laboratory results indicated the TSH and the Free T4 were obtained on 12/3/12. The BMP was not obtained on 12/3/12.</p> <p>Interview with LPN #2 on 2/7/13 at 8:32 a.m., indicated the Physician Orders on 12/1/12 indicated a BMP was to be drawn. She indicated there was no evidence that the BMP was obtained. There was no evidence of any potassium level in the laboratory results.</p> <p>Further interview with LPN #2 on 2/7/13 at 8:32 a.m., indicated there was no indication for the use of the potassium supplement in the record.</p> <p>Interview with the Medical Records Supervisor on 2/8/13 at 11:43 a.m., indicated there was no evidence for the indication for the use of potassium supplement in the medical record. She also indicated there was no potassium level obtained for the resident from admission on 12/1/12 through 2/7/13. She indicated the BMP was not obtained as ordered by the Physician on 12/1/12.</p>			

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	<p>2. Resident #96's record was reviewed on 02/06/13 at 1:17 p.m. The resident's diagnoses included, but were not limited to, fractured humerus, congestive heart failure, hypokalemia, and vascular dementia. The resident was admitted into the facility on 01/16/13.</p> <p>A hospital History and Physical, dated 01/11/13, indicated the resident's potassium level on 01/11/13 was 3.0 (low) (normal 3.5-5.2) and the resident had hypokalemia (low potassium) and iron deficiency anemia.</p> <p>The resident's admission orders included the following medications: Lasix 20 milligrams (mg) daily (diuretic) hydrochlorothiazide 12.5 mg daily (diuretic) Hyzaar 100-12.5 mg daily (diuretic) ferrous sulfate 325 mg daily (iron)</p> <p>A physician's progress note, dated 01/16/13, indicated a laboratory test orders to check the resident's BMP (electrolytes), CBC (complete blood count), and iron levels.</p> <p>There was a lack of documentation to indicate the resident's laboratory test orders had been completed as</p>				

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	<p>ordered to assist in monitoring the resident's medications.</p> <p>During an interview on 02/06/13 at 2:55 p.m., the Medical Records Nurse indicated the laboratory tests had not been completed.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the Pharmacist Consultant report was acted upon for 1 of 10 residents reviewed for unnecessary medications. (Resident #6)</p> <p>Findings include:</p> <p>The record for Resident #6 was reviewed on 2/6/13 at 8:00 a.m. The resident had diagnoses that included, but were not limited to, diabetes, anxiety and depression. The resident's date of birth was 5/5/47, she was 65 years old.</p> <p>There was a current Physician Order dated 3/26/12, that indicated, "citalopram (an antidepressant medication) 40 mg (milligrams) 1 tablet orally at bedtime and 20 mg orally at bedtime to equal 60 mg."</p> <p>There was a Pharmacist recommendation dated 5/2/12, that</p>	F0428	<p>F428 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Physician of Resident #6 was notified and appropriate documentation was obtained from physician of clinical rationale for decline of Gradual Dosage Reduction (GDR) for medication (Citalopram), however has indicated that medication would be trialed as a reduction. 2) How the facility identified other residents: Facility completed audit of pharmacist recommendations for GDR's completed in the last 30 days to ensure documentation of clinical rationale is present when recommendations for GDR's are declined. 3) Measures put into place / System</p>	03/14/2013	

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	<p>indicated: "(Resident #6's name) is receiving Citalopram 60 mg (20 mg & 40 mg) at a dose of greater than 20 mg daily. An FDA (Federal Drug Administration) Safety Alert released March 28, 2012, states that the maximum dose of Citalopram for patients greater than 60 years of age is 20 mg daily due to the potential risk of abnormal heart rhythms with high doses. Recommendation: Please consider decreasing Citalopram to 20 mg orally daily."</p> <p>There was documentation written on the recommendation that indicated, "Behavior Meeting-no current symptoms of depression can we reduce as above?"</p> <p>The Physician checked the box that indicated, "I decline the recommendation(s) above and do not wish to implement any charges due to the reasons below. Rationale: " The area was blank, no rationale was provided by the Physician. The Physician checked the box on 6/17/12.</p> <p>There was a Pharmacist recommendation dated 7/11/12, that indicated: "(Resident #6's name) is receiving</p>		<p>changes: Nursing Managers, Medical Record Nurse and Social Services will be re-educated regarding required documentation of clinical rationale for decline of GDR's. The DON/designee will complete a review of pharmacist recommendations for GDR requests monthly to ensure that documentation of clinical rationale for decline of GDR's are present upon receipt from physician. 4) How the corrective actions will be monitored: Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person DON/Designee 6) Date of Compliance March 14, 2013</p>		

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	<p>Citalopram 60 mg (20 mg & 40 mg) at a dose of greater than 20 mg daily. An FDA Safety Alert released March 28, 2012, states that the maximum dose of Citalopram for patients greater than 60 years of age is 20 mg daily due to the potential risk of abnormal heart rhythms with high doses.</p> <p>Recommendation: Please consider decreasing Citalopram to 20 mg orally daily."</p> <p>The Physician checked the box that indicated, "I decline the recommendation(s) and do not wish to implement any changes due to the reasons below. Rationale:" The area was blank. The Physician signed the recommendation but did not date it.</p> <p>Interview with the Social Service Director on 2/7/13 at 10:39 a.m., indicated the resident has not shown signs of depression. She indicated she had requested the Physician to review the medication use. She indicated the Physician had not reduced the citalopram as recommended by the Pharmacist and did not indicate a rationale for not reducing the Citalopram.</p> <p>The policy titled Medication Regime Review dated 12/1/07, was provided</p>				

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	<p>by the Director of Nursing on 2/8/13 at 8:35 a.m. She indicated the policy was current. The policy indicated: "Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR (Medication Regimen Review) and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention. Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendation contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why recommendation was rejected."</p> <p>3.1-25(j)</p>			

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F0431 SS=D	<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, interview, and record review, the facility failed to ensure multi-dose vials of insulin were labeled when opened for 1 of 2 insulin</p>	F0431	<p>F431</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission</p>	03/14/2013			

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	<p>dependent diabetics on the North hall and 1 of 5 insulin dependent diabetics on the West hall. (Residents #34 and #69)</p> <p>Findings include:</p> <p>1. Observation of the Medication Cart for the North hall on 2/7/13 at 3:09 p.m., indicated a vial of Humalog insulin located in a small plastic bag with the date of 2/14 written on it. Resident #34's last name was written on the vial. There was no date indicating when the vial had been opened.</p> <p>Interview with LPN #5 at the time, indicated the insulin had been gotten out of the Emergency Drug Kit (EDK) a few days ago and a date opened should have been written on the vial or plastic bag. She indicated that she did not know what the date of 2/14 signified.</p> <p>2. Observation of the Medication Cart for the West hall on 2/7/13 at 3:24 p.m., indicated a vial of Novolin R insulin for Resident #69 had been opened. The "date opened" sticker was blank and there was no documentation anywhere else on the vial or bottle to indicate when the vial had been opened.</p>		<p>that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: The insulin vials for Residents #34 and #69 were labeled with date opened.</p> <p>2) How the facility identified other residents: Audit was completed of all medication carts and medication rooms to check for opened medication vials without date open labeled, and no further issues were identified.</p> <p>3) Measures put into place / System changes: Licensed staff will be re-educated regarding the procedure for labeling of date open on required medications. Audits will be completed of medication carts, medication rooms and medication refrigerators at least twice weekly to monitor for labeling of date open on required medications. Staff will be addressed and re-educated if concerns are noted.</p> <p>4) How the corrective actions will be monitored: Results of audits will be reviewed in the monthly Quality Assurance</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Interview with LPN #4 at the time, indicated there was no date on the insulin to indicate when it was opened.</p> <p>Review of the facility policy "Accessing a Multi-dose Vial" on 2/7/13 at 4:20 p.m., which was provided by the Director of Nursing and identified as current, indicated the following: "Vials will be labeled, after opening, with: resident's name, date and time, and nurse's initials."</p> <p>3.1-25(k)(6)</p>		<p>meeting x 6 months.</p> <p>5) Responsible Person DON/Designee</p> <p>6) Date of Compliance March 14, 2013</p>		

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F0465 SS=F	<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. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred floors and walls, marred bathroom cabinets, dusty ceiling vents, stained light covers, cracked ceiling tiles, torn wheelchair arms, stained grout, soiled IV (intravenous) pole, dusty heat vents, mildew on tile, missing tile, burnt out lights, and stained ceiling tile on 4 of 4 units throughout the facility, 2 of 2 dining rooms, and 1 of 1 kitchens. This had the potential to effect the 57 residents residing in the facility. (The North, South, West and ACU halls, the Restorative and Main dining room and the Main kitchen.)</p> <p>Findings include:</p> <p>1. Random observations on 2/4 and 2/5/13 as well as during the Environmental Tour on 2/7/13 at 1:45 p.m., with the Maintenance and Housekeeping Supervisors, indicated the following:</p> <p>The North Hall</p>	F0465	<p>F 465 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for rooms identified North Hall: a. Room #1, Sanded and repainted Bathroom door. b. Room #2, Chipped edge of sink repaired, sanded and refinished. Repaired 4 inch by 1 inch broken piece of laminate. c. Room #7, Vanity having been identified with broken area of laminate has been repaired. d. Room # 12 and #14 Common shared sink 3' by 2" section under vanity identified as being marred has been sanded repainted door guard protector ordered from vendor will be installed under vanity for additional protection. e. Room #16, Sanded and repainted scratched and marred cabinet. f. Central bathroom, two drawers identified as being off track have been re-secured and cabinet base has been sanded and repainted. A capital expense has been submitted with corporate</p>	03/14/2013			

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	<p>a. The bottom of the bathroom door in Room #1 was observed to be scratched, marred and gouged. One resident resided in this room.</p> <p>b. The bathroom vanity in Room #2 was observed with 2 chipped areas along the edge of the sink and a 4 inch by 1 inch broken piece of laminate. Two residents resided in this room.</p> <p>c. The bathroom vanity in Room #7 was observed with broken areas of laminate. Two residents resided in this room.</p> <p>d. A 3 feet by 2 inch section wall underneath the bathroom sink for Rooms #12 and #14 were scratched and marred. Two residents resided in Room #12 and one resident resided in Room #14.</p> <p>e. The bathroom cabinet in Room #16 was observed to be scratched and marred. Two residents resided in this room.</p> <p>f. The Central bathroom was observed to have 2 of 2 vanity drawers off the track as well as the cabinets being marred. There was a lime build up around the tub fixtures</p>		<p>office for the replacement of dated tub and bathing lift; existing equipment maybe considered dated as manufacturer has gone out of business. Assessment by maintenance personnel suggests replacement of existing tub. Local vendor has been contacted and replacement of discolored grout is to be replaced. g. Accumulation of dust in ceiling vent near room #11, vent removed and cleaned. h. Heating vent by central bathing room in hallway protruding on left hand side, Vent has been removed and protrusion was corrected, vent replaced. 1) Immediate actions taken for rooms identified South Hall: a. Rooms #19 and #20, Excess wash basins removed and bed pans placed in clear plastic bags. b. Room # 21, Sanded and repainted marred and scratched areas. c. Room #22, Cabinet identified as scratched and marred sanded and repainted. d. Room # 23, Bathroom heater had an accumulation of dust, cover was removed and heater cleaned. e. Room # 24, Bathroom heater had an accumulation of dust, cover was removed and heater cleaned. Bathroom door was sanded and scratches repainted. f. Inside of Bathroom door in room #29 was scratched and marred, door has been sanded and repainted. g. Arm rest indentified as being lose on the right of toilet seat in central bath has been re-secured. Vanity</p>		

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	<p>and the inside of the tub was discolored. The grout in the first shower stall was discolored. Nineteen residents resided on the North hall.</p> <p>g. An accumulation of dust was observed in the ceiling vent outside of Room #11.</p> <p>h. The heating vent located along the base of the floor had an edge protruding on the left hand side of the unit. The vent was located by the Central bathroom.</p> <p>The South hall</p> <p>a. On 2/4/13 at 3:18 p.m., nine wash basins were stored in the bathroom of Rooms #19 and #20, the basins were stacked on top of each other and placed in a cabinet with an uncovered bed pan. Interview with CNA #6 at the time, indicated the wash basins should not have been stacked on top of each other. One resident resided in Room #19 and #20.</p> <p>b. The bathroom cabinet in Room #21 was observed to be marred and scraped. Also, the wood strip was observed off the back of the door.</p>		<p>was sanded repainted h. outside of room #22, crack in wall above door was resurfaced, sanded, primed, and repainted. i. Ceiling Tile identified in restorative dining room located by a sprinkler head was replaced and the vent identified as hanging loose from the ceiling was cleaned and reattached flush to tile. j. Main dining room 2 of 16 plastic light covers identified as being discolored with orange substance were removed, cleaned, and reinstalled. 1) Immediate actions taken for rooms identified on ACU Hall: a. Resident #61 in Room #102, had a wheel chair arm that was torn. Arm pad was replaced. Linoleum in bathroom floor was cracked and has been identified as needing to be replaced; an order has been placed with an outside contractor. Bathroom heater had an accumulation of dust, cover was removed and heater cleaned. b. Room #107, Bathroom door had a hole in the door surface which was patched, sanded, painted and repaired. Resident #51 had an wheel chair arm that was torn, arm pad was replaced. Cracked linoleum is scheduled to be replaced by March 14, 2013, and accumulation of dust was cleaned from the bathroom heater. c. Room #108, Veneer on two over the bed tables was coming off; both over the bed tables were replaced. d. Room #110,</p>		

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	<p>Two residents resided in this room.</p> <p>c. The bathroom cabinet in Room #22 was observed to be scratched and marred. One resident resided in this room.</p> <p>d. On 2/4/13 at 3:44 p.m., the heater in the bathroom of Room #23 was observed to have an accumulation of dust. Two residents resided in this room.</p> <p>e. The bathroom door in Room #24 was observed to be scraped and marred. Further, on 2/5/13 at 8:14 a.m., an accumulation of dust was observed in the heater in the bathroom. One resident resided in this room.</p> <p>f. The inside of the bathroom door for Room #29 was scratched and marred. Two residents resided in this room.</p> <p>g. The arm rest for the right side of the toilet seat in the Central bathroom was observed to be lose. The bathroom vanity was scratched and marred. Twenty-two residents resided on this hall.</p> <p>h. A crack in the upper edge of the wall as well as a tear in the wallpaper</p>		<p>Bathroom vent fan was making a loud noise; fan was lubricated and noise is not apparent any longer. e. Room #111, Vanity was marred and scratched; repairs were made to correct scratches. f. Bathroom door located in the activity room for the ACU was marred. Door has been sanded and repainted. Mirror was discolored at base; a new mirror has been installed to replace existing mirror. g. Laminate floor in ACU dining room has been marred and scratched; floor is to be replaced due to condition and bids are being obtained from local contractors. h. The grout in the first stall of the ACU central Bath in the first shower stall has been discolored. Bids are being obtained from contractors to replace discolored grouting and reseal shower tile. 1)</p> <p>Immediate actions taken for rooms identified on West Hall: a. Resident #37 who resides in Room #114, the wheel chair arm rests was cracked and has been replaced. b. Room #116, the IV pole was soiled, pole was cleaned. c. The Kitchenette had a marred area on painted surface; area was sanded and repainted. Plastic light cover was soiled with an orange discoloration; surface has been cleaned. During brief initial sanitation tour with the Dietary supervisor on 2/4/13, the following was observed. 1)</p>		

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	<p>border was observed outside of Room #22.</p> <p>i. In the Restorative dining room, a ceiling tile that was located by the sprinkler head was cracked in half and a vent fixture loose and hanging from the ceiling tile.</p> <p>j. In the Main dining room, 2 of 16 plastic light covers were observed to discolored with an orange substance.</p> <p>ACU hall</p> <p>a. On 2/4/13 at 11:37 a.m., the wheelchair arm for Resident #61, who resided in Room #102, was observed to be torn. The resident's bathroom had cracked linoleum along the edge of the floor and the heater on the wall had an accumulation of rust. One resident resided in this room.</p> <p>b. The bathroom door in Room #107 was observed to be cracked on the outside with a small hole present. There was a crack in the linoleum along the edge of the bathroom floor. The wheelchair arms for Resident #51, who resided in this room, were cracked and torn. One resident resided in this room.</p> <p>c. The veneer was observed to be</p>		<p>Immediate actions taken for sanitation concerns identified on tour:</p> <p>a. Black stain of mildew on back of sink; Area cleaned and repainted by the back splash area. b. Two of three ceiling vent fans were observed to be hanging away from ceiling and in need of repair; Repairs were made to the vent fans and they were reinstalled flush with ceiling. c. There were three ceramic tiles missing on the wall in the in the dish room; Ceramic tiles have been replaced and re-grouted, area resealed. d. Two of twelve overhead ceiling lights were observed burned out; Lights have been repair with new starter ballasts installed. During brief kitchen sanitation tour with the Dietary supervisor on 2/5/13, the following was observed. 1) Immediate actions taken for sanitation concerns identified on tour: a. There was a liquid spattered on ceiling, area has been thoroughly cleaned. b. Outside door to the walk-in freezer has been marred with painted chipped; the area has been cleaned and repainted. c. Door to the walk in freezer has a seal that is damaged; a new seal has been installed to this area. 2) How the facility identified other environmental concerns: a. A 100% room inspection has been completed by the maintenance director and the environmental services</p>		

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	<p>coming off both over bed tables in Room #108. Two residents resided in this room.</p> <p>d. On 2/4/13 at 11:47 a.m., the bathroom fan in Room #110 was making a loud noise. One resident resided in this room.</p> <p>e. The bathroom vanity in Room #111 was observed to be scratched and marred. One resident resided in this room.</p> <p>f. The bathroom door located in the Activity room was marred. The mirror located in the bathroom was discolored at base. A section of peeled paint was observed behind the gray plastic cabinet. Eleven residents resided on the unit.</p> <p>g. The laminate floor in the ACU dining room was scratched and marred. Eleven residents resided on the unit.</p> <p>h. The grout in the first stall of the Central bath was discolored. Eleven residents resided on this unit.</p> <p>West hall</p> <p>a. On 2/4/13 at 1:56 p.m., the wheelchair arms for Resident #37,</p>		<p>director. The inspection identified areas needing additional repair.</p> <p>3) Measures put into place / System changes: a. Maintenance director will compile a list of rooms to be checked monthly for repairs. b. Housekeeping supervisor has revised a monthly deep clean room schedule. c. Dietary manager has revised a specific monthly cleaning schedule for all dietary areas. 4) How the corrective actions will be monitored: a. Administrator/Designee will inspect all deep cleaned rooms for quality assurance monthly for six months then 3 random rooms' monthly audits each month for six months. Administrator/Designee will report all findings at monthly Quality Assurance meeting. 5) Responsible Person Administrator/Designee 6) Date of Compliance March 14, 2013</p>		

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	<p>who resided in Room #114 were cracked. Two residents resided in this room.</p> <p>b. On 2/4/13 at 12:52 p.m., the IV (intravenous) pole located in Room #116 was soiled with a light brown substance. One resident resided in this room.</p> <p>c. The kitchenette had an area of marred paint located near the microwave oven and a plastic light cover was discolored with an orange substance.</p> <p>Interview with the Houskeeping and Maintenance Supervisors at the time, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>2. During the Brief Initial Sanitation Tour on 2/4/13 at 8:42 a.m., with the Dietary Manager, the following was observed:</p> <p>a. There was black stain of mildew on the back splash of the sink in the dish room.</p> <p>b. Two of three ceiling vents in the dish room were observed to be hanging away from the ceiling. The vents were in need of repair.</p> <p>c. There were three missing ceramic</p>			

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	<p>tiles on wall in the dish room.</p> <p>d. Two of 12 ceiling lights were observed burned out.</p> <p>Interview with the Dietary Manager at the time of the Brief Kitchen Sanitation Tour, indicated the above areas were in need of repair and/or cleaning.</p> <p>3. During the Kitchen Sanitation Tour on 2/5/13 at 3:15 p.m., the following was observed with the Dietary Manager:</p> <p>a. There was a liquid splatter on the ceiling above the food prep area.</p> <p>b. The outside of the door to the walk-in freezer was marred with chipped paint.</p> <p>c. There was a gap between the door frame of the walk-in freezer and the rubber gasket on the freezer door. Cold air from the freezer could be felt coming out of the freezer.</p> <p>Interview with the Dietary Manager at the time of the tour, indicated the above areas were in need of cleaning and /or repair.</p> <p>3.1-19(f)</p>				

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F9999	<p>3.1-14 PERSONNEL</p> <p>In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six and three hours of dementia specific training annually for 33 of 75 employees who had been employed at the facility for more than six months. (Assistant Director of Nursing, RN #2, RN #3, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, QMA #1, QMA #2, CNA#4, CNA #8, CNA #9, CNA #10, CNA #11, CNA #12, CNA #13, CNA #14,</p>	F9999	<p>F9999</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those employees identified:</p> <p>The following indicated employees: (ADON, RN #2, RN #3, LPN #'s 5, 6, 7, 8, 9,; QMA #'s 1 and 2; CNA #'s 4, 8, 9, 10, 11, 12, 13, 14, 15 and 16; Dietary Aide #'s 1 and 2; Housekeeper #'s 1, 2, 3; Staff Coordinator; MDS; Laundry Aide #1; Maintenance Supervisor; Medical Records Coordinator; Activity Director; Physical Therapy #'s 1 and 2) will be provided self-study dementia in-services and post-tests to complete required 6 hour or 3 hour training. 2) How the facility identified other employees:</p> <p>Human Resources will complete full audit of employee files to note which employees are deficient and how many hours needed.</p> <p>3) Measures put into place / System changes:</p> <p>Department Managers will be</p>	03/14/2013			

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	<p>CNA #15, CNA #16, Dietary Aide #1, Dietary Aide #2, Housekeeper #1, Housekeeper #2, Housekeeper #3, Staff Coordinator, Minimum Data Nurse, Laundry Aide #1, Maintenance Supervisor, Medical Records Nurse, Activity Director, Physical Therapy #1, and Physical Therapy #2)</p> <p>Findings include:</p> <p>33 employees who had been employed by the facility for over four months, records were reviewed on 02/11/13 at 11 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 33 of the 75 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2012.</p> <p>During an interview on 02/11/13 at 11:30 a.m., Human Resources indicated they put a list up for those who need dementia training and the Supervisors are responsible to ensure the training is completed.</p> <p>3.1-14(u)</p>		<p>re-educated regarding new employee documentation requirements and deadlines for completion.</p> <p>Human Resources Coordinator will audit new employee files 2 times a month to ensure all required paperwork and documentation are present. Administrator and responsible department manager will be notified of any deficiencies. Status of employee file deficiencies will be reviewed during Morning Meeting at least once a week.</p> <p>The Administrator will be responsible for oversight of audits and enforcement of deadlines for completion of new employee documentation.</p> <p>4) How the corrective actions will be monitored:</p> <p>Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months.</p> <p>5) Responsible Person Administrator /Designee</p> <p>6) Date of Compliance March 14, 2013</p>				

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R0000	The following State Residential findings cited are in accordance with 410 IAC 16.2.	R0000			

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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
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R0095	<p>410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six and three hours of dementia specific training annually for 33 of 75 employees who had been employed at the facility for</p>	R0095	<p>R 0095The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p>	03/14/2013			

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	<p>more than six months. (Assistant Director of Nursing, RN #2, RN #3, LPN #5, LPN #6, LPN #7, LPN #8, LPN #9, QMA #1, QMA #2, CNA#4, CNA #8, CNA #9, CNA #10, CNA #11, CNA #12, CNA #13, CNA #14, CNA #15, CNA #16, Dietary Aide #1, Dietary Aide #2, Housekeeper #1, Housekeeper #2, Housekeeper #3, Staff Coordinator, Minimum Data Nurse, Laundry Aide #1, Maintenance Supervisor, Medical Records Nurse, Activity Director, Physical Therapy #1, and Physical Therapy #2)</p> <p>Findings include:</p> <p>33 employees who had been employed by the facility for over four months, records were reviewed on 02/11/13 at 11 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 33 of the 75 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2012.</p> <p>During an interview on 02/11/13 at 11:30 a.m., Human Resources indicated they put a list up for those who need dementia training and the Supervisors are responsible to ensure the training is completed.</p>		<p>1) Immediate actions taken for those employees identified: The following indicated employees: (ADON, RN #2, RN #3, LPN #'s 5, 6, 7, 8, 9,; QMA #'s 1 and 2; CNA #'s 4, 8, 9, 10, 11, 12, 13, 14, 15 and 16; Dietary Aide #'s 1 and 2; Housekeeper #'s 1, 2, 3; Staff Coordinator; MDS; Laundry Aide #1; Maintenance Supervisor; Medical Records Coordinator; Activity Director; Physical Therapy #'s 1 and 2) will be provided self-study dementia in-services and post- tests to complete required 6 hour or 3 hour training. 2) How the facility identified other employees: Human Resources will complete full audit of employee files to note which employees are deficient and how many hours needed. 3) Measures put into place / System changes: Department Managers will be re-educated regarding new employee documentation requirements and deadlines for completion. Human Resources Coordinator will audit new employee files 2 times a month to ensure all required paperwork and documentation are present. Administrator and responsible department manager will be notified of any deficiencies. Status of employee file deficiencies will be reviewed during Morning Meeting at least once a week. The Administrator will be responsible for oversight of</p>				

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			audits and enforcement of deadlines for completion of new employee documentation. 4) How the corrective actions will be monitored: Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person Administrator /Designee 6) Date of Compliance March 14, 2013		

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R0144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the facility was clean and orderly for 2 of 5 resident's rooms observed, related to torn carpeting, urine odor, cluttered room, loose baseboard, brown/black substance build up on floor, caulking, sink, and wall, scraped bathtub, loose bathroom counter trim, rusted drain on a sink. This had the potential to affect 3 residents. (Residents #2, #3, and #5)</p> <p>Findings include:</p> <p>During an observation on 02/08/13 at 3:10 p.m., Resident #5's room had torn carpeting and a strong urine odor.</p> <p>During an observation on 02/08/13 at 3:15 p.m., Resident #2 and #3's room was cluttered with boxes and clothing from Resident #2's side of the room. The carpeting was stained and torn. The sink drain in the kitchenette was discolored.</p> <p>Resident #2 and #3's bathroom had loose baseboard on the wall behind</p>	R0144	<p>R 0144</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for rooms identified in Residential Hall:</p> <p>a. On 2/8/2013, Residents Identified as #2 and #3, were both offered a remodeled apartment across the</p>	03/14/2013			

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	<p>the toilet, there were towels all over the bathroom floor, Loose veneer trim on the sink, a black substance on the wall by the sink, a black substance on the caulking around the sink, there was an accumulation of a brown/black substance on the floor and corners around the bathtub and the caulking around the base of the toilet. The bathtub was marred and grout around the tiles of the shower were dirty and there were scrapes on the wall.</p> <p>During an interview on 02/08/13 at 3:20 p.m., the Administrator indicated he could not say what the black substance was in the bathroom.</p> <p>At the time of the observation, Resident #2 indicated the carpeting was stained when he moved into the room and he was embarrassed of the way the carpeting looked.</p>		<p>hall from their present room, which has comparable semi private accommodations: Having walls which separate the residents bedroom areas. A patio area of equal size with sliding door access provided and a kitchenette with microwave and refrigerated storage.</p> <p>On 2/8/2013, Residents Identified as #2 and #3, were assisted with cleaning, packing, and moving of belongings and furniture to room #. Both residents expressed satisfaction with move and new accommodations and assistance with organization of personal belongings.</p> <p>b. Resident Identified as #5, torn carpet near entrance doorway area was repaired on 2/9/2013 and room measured for new carpeting. Outside contractor has replaced living room carpet and resident has express satisfaction with replacement carpet. Resident's room and furniture has been deep cleaned.</p> <p>3) Measures put into place / System changes:</p> <p>a. Maintenance director will compile a list of Assisted Living</p>		

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			<p>rooms to be checked monthly for repairs and work orders for repairs will be completed and a record for those repairs will be kept in the maintenance supervisor's office.</p> <p>b. Housekeeping supervisor has revised weekly room cleaning schedule and a monthly deep clean room schedule for the Assisted Living, a record for the revised room cleaning schedule will be maintained in the housekeeping supervisor's office.</p> <p>4) How the corrective actions will be monitored:</p> <p>a. Administrator/Designee will inspect repairs and all deep cleaned rooms for quality assurance monthly for six months then 3 random rooms' monthly audits each month for six months. Administrator/Designee will report all findings at monthly Quality Assurance meeting.</p> <p>5) Responsible Person</p> <p>Administrator/Designee</p>		

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			6) Date of Compliance March 14, 2013		

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R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure physicians' orders were followed, related to medications not held as ordered and a medication discontinued without an order for 1 of 6 residents reviewed for physician's orders in a total sample of 6 (Resident #2) and medications not given as ordered for 1 supplemental resident (Resident #9) in a total supplemental sample of 2 for 5 residents observed during medication administration. (QMA #3)</p> <p>B. Based on record review and interview, the facility failed to ensure the provision of care was supervised by a licensed nurse, related to blood pressure medication held without notification and assessment of the licensed nurse for 1 of 6 residents reviewed for medications in a total sample of 6. (Resident # 2)</p> <p>Findings include:</p>	R0241	<p>R 0241 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Medication Error Report was completed on QMA #3 for Resident #9 and MD notified. Order obtained to check Valproic Acid level which came back indicating within therapeutic level. No harm occurred to resident. Resident #2, MD notified for order to discontinue Zyrtec. Zyrtec was not administered so duplication of medication administration did not occur. No harm to resident. 2) How the facility identified other residents: Medication Administration Records and medications of all residents were reviewed since 02-01-13 for any medication parameters not being</p>	03/14/2013			

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	<p>A1. During a medication administration on 02/08/13 at 7:50 a.m., QMA #3 prepared Resident #9's medication, which included liquid Valporic Acid (mood stabilizer) 200 mg (milligram) (4 milliliters).</p> <p>QMA #3 poured the valporic acid into a plastic medication cup. Observation of the liquid in the cup indicated there was a little less than 5 milliliters in the graduated medication cup.</p> <p>QMA #3 indicated she pours, "a little less than 5", (milliliters) in the medication cup. She indicated she could probably use a syringe to measure out 4 milliliters of the liquid, but the facility doesn't use syringes. QMA #3 then administered the liquid medication to the resident.</p> <p>Resident #9's record was reviewed on 02/11/13 at 8:30 a.m. The resident's diagnoses included, but were not limited to, delusional disorder and psychotic disorder.</p> <p>The Physician's Recapitulation orders, dated 01/13, indicated an order for valporic acid 250 mg/5 ml (milliliters) give 4 ml (200 mg) orally every morning.</p> <p>A facility policy, dated 05/01/10, titled</p>		<p>followed per facility protocol; as well as medications discontinued without physicians' order and physicians notified as indicated.</p> <p>3) Measures put into place / System changes: In-service training held for all licensed nursing staff including QMA's on obtaining vitals as ordered for medications and if vitals are within parameters that medications need to be held, QMA will obtain direction from licensed nurse on holding medication. When administration of a PRN medication by a QMA, permission will be documented including nurse's name. QMAs may only do follow up documentation on a PRN when an assessment is not required such as when the resident is able to state the effectiveness of the medication and an assessment is not required. All licensed nursing staff were in-serviced on correct dosing of liquid medications by use of syringe to draw up correct dose. 4) How the corrective actions will be monitored: Pharmacy audit will be conducted monthly and any discrepancies will be noted on audit. DON/Designee will audit QMA medication administration entries 3 times a week for PRN administration and follow-up documentation. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months.</p>				

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	<p>, "General Dose Preparation and Medication Administration" received from the DoN (Director of Nursing) as current, indicated, "...Facility staff should use an oral dose syringe for measuring small and/or fractioned volumes of liquid medication..."</p> <p>A2. Resident #2's record was reviewed on 02/11/13 at 9:40 a.m. The resident's diagnoses included, but were not limited to, stroke and hypertension.</p> <p>1. The Physician's Recapitulation Orders, dated 02/13, indicated an order for Lisinopril 20 mg (Blood Pressure Medication) every 12 hours, hold if blood pressure less than 110/70.</p> <p>The January 2013 Medication Administration Record (MAR) indicated the resident's blood pressure at 8 p.m. on 01/11/13 was 101/64 and the Lisinopril was administered.</p> <p>The February 2013 MAR indicated the resident's blood pressure at 8 p.m. on 02/05/13 was 112/53 and the Lisinopril was administered and on 02/10/13 the resident's blood pressure was 96/60 and the Lisinopril was administered.</p>		<p>5) Responsible Person DON /Designee</p>				

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	<p>During an interview on 02/11/13 at 10:20 a.m., the Medical Records Nurse indicated the Lisinopril was not held as ordered.</p> <p>2. The Physician's Recapitulation Orders, dated 02/13, indicated an order (12/31/12) for Clariton 10 mg daily for nasal congestion.</p> <p>A physician's order, dated 02/06/13, indicated Zyrtec 10 mg daily at bedtime for nasal congestion.</p> <p>A Nurses' Note, dated 02/07/13 at 1 p.m., indicated, "Called MD...need clarification. MD ordered Zyrtec & resident is on loratadine (Clariton). Pharmacy is asking to d/c (discontinue) loratadine. MD has not responded..."</p> <p>The MAR, dated 02/13, indicated the Claritin was discontinued on 02/07/13 and had not been given since 8 a.m. on 02/06/13.</p> <p>There was a lack of documentation to indicate the resident's physician had discontinued the Claritin.</p> <p>During an interview on 02/12/13 at 8:45 a.m., the Director of Nursing indicated she could not locate an</p>			

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	<p>order for the Claritin to be discontinued.</p> <p>B1. Resident #2's record was reviewed on 02/11/13 at 9:40 a.m. The resident's diagnoses included, but were not limited to, stroke and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 02/13, indicated an order for Lisinopril 20 mg (Blood Pressure Medication) every 12 hours, hold if blood pressure less than 110/70.</p> <p>The MAR, dated 01/13/13, indicated the resident's Lisinopril was held by the QMA on January 9, 12, 14, 25, and 28, 2013 due to the blood pressure was out of the ordered parameters.</p> <p>There was a lack of documentation to indicate the Licensed Nurse had been made aware and assessed the low blood pressure and the medication being held.</p> <p>During an interview on 02/11/13 at 10:15 a.m., RN #2 indicated the QMA's are suppose to tell the nurse if medications are held so the nurse could assess the resident.</p>						

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R0246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure as needed medication (PRN) were only administered upon authorization by a licensed nurse or physician, for 1 of 6 residents reviewed for PRN medication in a total sample of 6. (Resident #2)</p> <p>Findings include:</p> <p>Resident #2's record was reviewed on 02/11/13 at 9:40 a.m. The resident's diagnoses included, but were not limited to, stroke and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 02/13, indicated the following PRN orders: (05/27/12) Acetaminophen 325 mg, one tablet every four hours prn pain (04/12/12) Fioricet (pain medication) 50/325/40, one tablet every six hours PRN breakthrough pain.</p>	R0246	<p>R 0246The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for those residents identified: Events for Resident # 2 occurred in the past and cannot be corrected. Resident has been assessed by licensed nurse and no harm noted. 2) How the facility identified other residents: Medication Administration Records were audited since 02-01-13 for QMA administration and requirement of nurse assessment. 3) Measures put into place / System changes: In-service training held for all licensed nursing staff including QMA's on obtaining vitals as ordered for medications and if vitals are</p>	03/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/12/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Medication Administration Record (MAR), dated 01/13, indicated the acetaminophen was administered by a QMA without prior authorization on January 1, 3, 5, 6, 8, 16, 22, 25, 29, and 31, 2013.</p> <p>The MAR and the Pain Monitoring Tool, dated 01/13, indicated the Fioricet was administered by a QMA without prior authorization on January 5, 6, 20, and 22, 2013.</p> <p>The MAR, dated 02/13, indicated the acetaminophen was administered by a QMA without prior authorization on February 2, 3, and 5, 2013.</p> <p>During an interview on 02/11/13 at 10:20 a.m., the Medical Records Nurse indicated there was no documentation of authorization from the nurse prior to the PRN medications being given.</p>		<p>within parameters that medications need to be held, QMA will obtain direction from licensed nurse on holding medication. When administration of a PRN medication by a QMA, permission will be documented including nurse's name. QMAs may only do follow up documentation on a PRN when an assessment is not required such as when the resident is able to state the effectiveness of the medication and an assessment is not required. 4) How the corrective actions will be monitored: DON/Designee will audit QMA medication administration entries 3 times a week for PRN administration and follow-up documentation. Results of audits will be reviewed in the monthly Quality Assurance meeting x 6 months. 5) Responsible Person DON /Designee</p>		