

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2014
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NAME OF PROVIDER OR SUPPLIER  RIVER POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN 47715
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00154146 and IN00155668.</p> <p>Complaint IN00154146 - Substantiated. Federal/State deficiencies related to the allegations are sited at F323 and F333.</p> <p>Complaint IN00155668 - Substantiated. Federal/State deficiencies related to the allegations are sited at F223, F225, and F226.</p> <p>Survey dates: September 16, 17, 18, 22, 23, 24, 25, 26, 2014</p> <p>Facility number: 002280 Provider number: 155723 AIM: 201068770</p> <p>Survey team: Diana Perry: RN,TC Diane Hancock RN -September 16, 17, 18, 23, 24, 2014 Barb Fowler RN- September 17, 18, 22, 23, 24, 25, 26, 2014 Denise Schwandner RN- September 17,18, 22, 23, 24, 25, 26, 2014</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000155 SS=D	<p>Anna Villain RN -September 17,18, 22, 23, 24, 25, 26, 2014</p> <p>Census bed type: SNF: 52 NF: 0 SNF/NF: 10 Residential: 38 Total: 100</p> <p>Census payor type: Medicare: 31 Medicaid: 8 Other: 23 Total: 62</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 2, 2014, by Jodi Meyer, RN</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</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</p>			

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	<p>advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>Based on record review and interview, the facility failed to comply with advanced directives for 1 of 3 residents reviewed for death, in that cardiopulmonary resuscitation was provided for a resident who had a physician's order for no resuscitation. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record of Resident #22 was reviewed on 9/18/14 at 9:02 a.m. Resident #22 had a diagnoses including, but not limited to, dementia with psychotic features, coronary artery disease, status-post pacemaker insertion, organic brain syndrome, cardiomyopathy, sick sinus syndrome, and diabetes mellitus type 2 (two). The clinical record indicated Resident #22 had an advanced directive, signed by the physician on 7/31/13, for a do not resuscitate (DNR) order. Resident #22 expired on 9/7/14.</p> <p>A nurse's note, dated 9/7/14 at 5:20 p.m.,</p>	F000155	<p>F155Res #22 deceased and no other residents were affected by the alleged deficient practice. All residents with a DNR status have the potential to be affected and have been reviewed for current code status wishes. Completion Date 10/26/14 Inservicing of staff and communication with local EPD will prevent future recurrence. Completion Date: 10/26/14 All CPR trained staff will be inserviced on procedure for carrying out code status requests and policy. Completion Date: 10/26/14 A communication to local EPD will explain our procedures and expectation that DNR status be verified upon their arrival before initiation of such techniques since their staff conducted the compressions upon arrival to facility Completion Date: 10/26/14 DHS or designee will review documentation of all deaths and CPR performed in campus for compliance with policy and resident wishes, with immediate training provided when necessary. Results of reviews will be forwarded to QA committee monthly x 12 months.</p>	10/26/2014

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	<p>indicated Resident #22 was found slumped over in a wheelchair in the dining room. Resident #22's apical pulse was found to be absent. After the finger sweeping of Resident #22's mouth was completed and the Heimlich maneuver was attempted without success, the resident was wheeled to the resident's room and placed in bed on a back board with oxygen being started. Resident #22 vital signs continued to be absent.</p> <p>A nurse's notes, dated 9/7/14 at 5:23 p.m., indicated an emergency call was placed for the paramedics and cardiopulmonary resuscitation (CPR) was started per protocol. The police department arrived. The note indicated chest compressions were terminated after the DNR was reviewed.</p> <p>A nurse's note, dated 9/7/14 at 5:35 p.m., indicated paramedics arrived at the facility where the DNR status was reviewed.</p> <p>A nurse's note, dated 9/7/14 at 5:40 p.m., indicated the family, the physician, and the coroner were notified of Resident #22's death.</p> <p>During an interview on 9/24/14 at 2:45 p.m., RN #1 indicated the code status of the residents is located on the face sheet</p>			

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F000223 SS=D	<p>with the MAR (Medication Administration Record) book and is also in the resident's clinical record.</p> <p>The "Guidelines for DNR Orders, obtained from the Administrator In Training, on 9/24/14 at 4:16 p.m., indicated do not resuscitate orders will remain in effect until the resident (or legal surrogate) provides the campus with a signed and dated request to end the DNR order.</p> <p>3.1-4(f)(7)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure that a resident was free from physical and verbal abuse for 1 of 3 residents reviewed in a sample of 30 residents interviewed during stage 1 of the survey. (Resident I)</p> <p>Findings include:</p>	F000223	F223Resident 1 had her safety and rights protected, and had no injuries from the treatment of CNA #1Completion Date:9/11/14All residents have the potential to be affected in the future but with screening, training and inservicing will ensure procedures are followed in accordance with company policy and state/federal requirements.Completion Date:	10/26/2014

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	<p>On 9/18/14 at 9:19 a.m., the clinical record review of Resident I was reviewed.</p> <p>Diagnoses included, but were not limited to, osteoarthritis, abnormality of gait, constipation, malignant neoplasm of nasal cavities, hypertension, coronary atherosclero, atrial fibrillation, congestive heart failure, asthma, esophageal reflux, arthropathy, and generalized pain.</p> <p>Resident I's BIMS (Brief Interview for Mental Status) score was 15/15, indicating no mental impairment.</p> <p>Social progress notes dated 9/11/14 at 1340, indicated RN #3 spoke with the resident regarding her concerns with the care she received from CNA #1 and the resident indicated that CNA #1 refused to clean her up when she rung the call light and that she had feces in her pants because it took too long for her to answer the light. The Resident I indicated that she rang the light again and a nurse came in to clean her up. Resident I indicated this happened right after dinner last night and that when she had rung the call light and asked CNA #1 to put her to bed, CNA #1 told her she couldn't be first. Resident I indicated that CNA #1 left the room and returned a while later and said it was time for the resident to go to bed. The resident indicated CNA #1 grabbed her arm and jerked on it, yelling at her to</p>		<p>10/26/14All departments inserviced regarding investigation procedures and reporting requirements as well as abuse prevention.Completion Date: 10/26/14ED will forward all reportables to QA committee monthly for review of compliance with investigation and state/federal requirements x 6 months and quarterly thereafter for review and further recommendations.</p>	

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	<p>get in bed. The resident indicated it all happened so fast and she didn't know why CNA #1 was mad at her. Resident I asked CNA #1 to take the bed spread off of her bed because it was too heavy and that CNA #1 refused to take the extra blanket off of the bed. Resident I indicated her face was covered up with blankets and CNA #1 left the room. The resident indicated that she didn't want CNA #1 taking care of her, but did not want her to get in trouble. At 4:00 p.m. the social progress notes indicate that RN #3 went back to the resident's room to assess the resident's skin and that no bruising was noted.</p> <p>Social progress notes dated 9/11/14 at 2:00 p.m., indicated that ISDH was notified of the incident and that Evansville City Police were called and given report. The police department requested that ISDH report be faxed to them.</p> <p>An interview with Resident I on 9/17/14 at 10:15 a.m., indicated that a CNA was hostile and flung her into bed. Resident I indicated that she reported the incident and that the social worker told her that the CNA had been discharged from her position.</p> <p>An interview with the Administrator on</p>			

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F000225 SS=D	<p>9/18/14 at 1:30 p.m., indicated that CNA #1 was terminated from employment at the facility related to the abuse allegation. She also indicated that there was another allegation by a resident indicating CNA #1 had an attitude problem and a poor demeanor.</p> <p>This Federal tag relates to Complaint IN00155668</p> <p>3.1-27(a)(1) 3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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>			

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	<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 interview and record review, the facility failed to ensure allegations of abuse were immediately reported to the Indiana State Department of Health in 1 of 3 allegations of abuse reviewed. (Resident C)</p> <p>Findings include:</p> <p>On 9/22/14 at 11:09 a.m. the clinical record of Resident C was reviewed. Diagnoses included, but were not limited to, UTI, congestive heart failure, fall, hypothyroidism, hyperlididemia, gout, atrial fib, conduction disorder of the heart, and thromboembolic disorder. The quarterly MDS (Minimum Data Set) Assessment dated 7/29/14, indicated Resident C's BIMS (Brief Interview for Mental Status) score was 13/15. Resident C's score indicated the resident</p>	F000225	F225Resident C no longer resides at the facility as stated in the 2567. Completion Date: 8/27/14 All residents in the future that have an allegation of abuse and investigation conducted as a result of the complaint have the potential to be affected by the alleged deficient practice therefore through inservicing and systematic changes stated below will ensure procedures are followed in accordance with company policy and state/federal requirements. Completion Date 10/26/14 All departments inserviced regarding investigation procedures and reporting requirements as well as abuse prevention. Completion Date: 10/26/14 Systemic change is ED will report all allegations immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting	10/26/2014

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	<p>had mild cognitive impairment.</p> <p>The nurses notes dated 8/27/14 at 10:50 p.m., indicated "The resident's left arm is extremely swollen and bruised, shoulder is warm/hot to touch and hand is ice cold - 2+ capillary refill noted. Uncontrollable pain in left arm, PRN Norco [narcotic pain medication] was administered with no relief. Notified son of current condition and he wanted to send her to the hospital. Notified physician triage of transfer. Resident left floor by ambulance 10:45 p.m.</p> <p>The Change in Condition Form dated 8/25/14 at 9:00 a.m. indicated "Increased bruising to abdomen and right shoulder, physician here. Looked at bruising." Follow up results dated 8/25/14 at 6:00 p.m. to 6:00 a.m. indicated "Resident continues to have large bruises all over body. Resident c/o [complains of] pain. PRN [as needed] meds given." Follow up results dated 8/26/14 indicated "Bruising remains, c/o pain to left arm. Will continue to monitor." Follow up results dated 8/26/14 "bruising remains c/o pain to left arm will continue to monitor." Follow up results dated 8/27/14 at 9:00 a.m. indicated "continues to have pain in left arm with bruising noted - PRN pain med given with routine and effective."</p>		<p>requirements reviewed for timely submission to agencies ensured. Completion Date: 10/26/14 ED will forward all reportables to QA committee monthly for review of compliance with investigation and state/federal requirements x 6 months and quarterly thereafter for review and further recommendations.</p>	

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	<p>Follow up results dated 8/27/14 at 6:00 p.m. - 6:00 a.m. indicated "bruising continues with shoulder, warm to touch, cold hands, 2+ capillary refill, c/o pain - PRN administered, no relief, notified son and physician triage, sent patient to the ER (emergency room) at 10:45 p.m."</p> <p>The Skilled Charting Evaluation dated 8/26/14 at 1:15 p.m. indicated that Resident C had left arm pain with verbal intensity of 9 (0 no hurt and 10 hurts worst) or moderate.</p> <p>The Skilled Charting Evaluation dated 8/27/14 at 1:35 p.m. indicated that Resident C had left arm pain with verbal intensity of 8 or severe.</p> <p>The Physician Orders dated 8/25/14 indicated orders to "monitor bruising posterior LUE (left upper extremity) q (every) shift T/H (until healed), may ice LUE QID (four times a day) PRN (as needed) discomfort, monitor right great toe q shift for s/s (signs and symptoms) infection - clipped with nail trimmer".</p> <p>An order dated 8/26/14 (error in documentation should be 8/27/14) at 10:45 p.m. indicated "okay to send patient to the ER (emergency room)".</p> <p>The Progress Notes dated 8/25/14, indicated "LUE [left upper extremity]: small round bruise posterior shoulder,</p>			

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	<p>consistent with w/c [wheel chair] support, bruising posterior upper arm to just below elbow, consistent with arm placement during nap".</p> <p>Hospital records from the hospital were obtained on 9/23/14 at 8:00 a.m. which included ambulance reports, radiology reports, emergency room records, photographs, and social service reports. The ambulance report dated 8/28/14 for 8/27/14 at 10:50 p.m. indicated Resident C's "Left arm has a large dark purple contusion all the way up her forearm. The pt's [patient's] hand is also purple. The pt's. upper arm is red and hot to the touch where as the hand is cold. The finger tips blanch and color returns in &lt;2 sec. [seconds]. There is a palpable pulse." The ambulance report also indicated "pt. states her left arm hurts and that pain is 10 on a scale of 10".</p> <p>The ER (emergency room) Physician Exam report dated 8/27/14 at 11:38 p.m. indicated "88 year old female presents to the ER with complaint of 9/10 sharp left arm pain that began at bedtime tonight. Nursing staff at patient's facility reports patient has a h/o [history of] DVT [deep vein thrombosis] in her LLE [left lower extremity] which she is on Lovanox [blood thinner] for. They report discoloration of the left arm for 3 days. Staff reports patient was grabbed on the</p>			

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	<p>left arm by nursing staff tonight. Patients denies any other acute falls or injuries. She denies chest pain." The physical exam indicated "Marked ecchymosis [bruising] and swelling of LUE. Tenderness of left upper arm and shoulder area. 2+ redial pulse bilaterally. Left hand: no discoloration.</p> <p>The ER nursing notes dated 8/27/14 at 11:41 p.m., indicated "Patient to room 16 c/o pain in left arm. Patient was 'roughed up' at nursing home and fingerprint shaped bruised noted on left upper arm. Pain Scale/Management instructed to patient/representative. Patient included in the plan of care. Positioned for comfort."</p> <p>Social service notes dated 8/28/14 at 3:15 p.m. indicated " Pt. [patient] is an 88 y/o year old female admitted 8/28/14 with dehydration, contusion of upper arms, multiple contusions. Hematoma to left upper extremity. Pt comes from SNF [skilled nursing facility], where she alleges the staff were 'rough' with her and caused the contusions. Pt. had a DVT a few months ago and was on anticoagulants. These are on hold for now. Pt. to have possible IVC [inferior vena cava] filter placed; MD [medical doctor] will discuss with son. SW [social worker] met with pt. by herself at first, and she told SW about how a staff at [name of facility] handled her roughly</p>			

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	<p>and caused her hematoma. Pt. was alert and oriented x 3, pleasant, cooperative, hard of hearing but otherwise able to communicate without difficulty. Pt. was almost tearful asking not to be sent back there. She asked SW to talk with her son about finding her another place. SW did this when son came to unit, and met with him in pt's. room."</p> <p>An interview on 9/23/14 at 10:12 a.m. with the facility Administrator, indicated that a family member came to the facility on 8/28/14 to file an allegation of mistreatment against a staff member. The family member indicated that CNA #1 was rude, rough, and was rushing the resident. An investigation was completed by the facility, but the Indiana State Department of Health was not notified of the allegation.</p> <p>On 9/17/14 at 11:00 a.m. the "Abuse and Neglect" policy, provided by the Administrator on 9/17/14 at 10:15 a.m. was reviewed. The policy indicated "...notification to the State Department of Health (per State guidelines and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated."</p> <p>This Federal tag relates to Complaint IN00155668</p>			

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F000226 SS=D	<p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the abuse policy was followed, in that, the policy did not include immediate notification of the Indiana State Department of Health in 1 of 3 allegations of abuse reviewed. (Resident I)</p> <p>Findings include:</p> <p>An interview on 9/23/14 at 10:12 a.m. with the facility Administrator, indicated that a family member came to the facility on 8/28/14 to file an allegation of mistreatment against a staff member. The family member indicated that CNA #1 was rude, rough, and was rushing the resident. She reviewed the investigation and indicated the Indiana State Department of Health was not notified of the allegation.</p> <p>On 9/17/14 at 11:00 a.m. the "Abuse and Neglect" policy, provided by the</p>	F000226	<p>F226Resident C no longer resides at the facility as stated in the 2567. Completion Date: 8/27/14All residents in the future that have an allegation of abuse and investigation conducted as a result of complaint have the potential to be affected by the alleged deficient practice therefore through inservicing and systemic changes stated below will ensure procedures are followed in accordance with company policy and state/federal requirements. Completion Date: 10/26/14All managers and departments inserviced regarding investigation procedures and reporting requirements as well as abuse prevention. Completion Date: 10/26/14Systemic change is ED will report all allegations immediately for review by Division Director of Operations/Clinical Support with all steps in investigation and reporting requirements reviewed for timely submission to agencies ensured. Completion Date: 10/26/14ED will forward all</p>	10/26/2014



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	<p>record review, the facility failed to provide a comprehensive care plan for 1 of 5 residents, who met the criteria for unnecessary medications, in a total sample of 36 residents reviewed, in that, a care plan was not initiated for an antipsychotic medication. (Resident #102)</p> <p>Findings include:</p> <p>On 9/23/14 at 11:10 a.m., Resident #102 was observed in her room with a right arm tremor. Her eyes were closed, however, she opened them to voice. Resident #102 indicated she was tired.</p> <p>On 9/24/14 at 8:02 a.m., Resident #102 was observed in the hallway with her eyes closed.</p> <p>On 9/22/14 at 4:06 p.m., Resident #102's clinical record was reviewed. Resident #102 was admitted on 12/19/13. Resident 102's diagnoses included, but were not limited to, psychotic dementia with behaviors. The most recent signed physician's recapitulation orders, signed 9/10/14, included, but were not limited to, Seroquel 50 mg (milligrams), give 1 tablet, orally every bedtime, initially ordered on 6/20/14.</p> <p>The Quarterly MDS (Minimum Data Set)</p>		<p>care and services related to antipsychotic medication use. Completion Date: 10/26/14 All residents receiving antipsychotic medications have the potential to be affected by the alleged deficient practice and have careplans updated to reflect care and services related to them. Completion Date: 10/26/14 Systemic change is that when a resident has an antipsychotic medication ordered there will be a careplan initiated and checked at the next clinical care meeting which occurs every normal business day (Monday-Friday). Completion Date: 10/26/14 Social Services and MDS coordinator will be inserviced on careplan initiation of antipsychotic meds. Completion Date: 10/26/14 DHS/Designee will monitor antipsychotic careplans daily for 30 days, then weekly for 30 days and monthly thereafter to ensure the use of the medication is addressed. Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.</p>				

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F000282 SS=D	<p>assessment, dated 6/28/14, indicated Resident #102 received an antipsychotic 7 out of 7 days.</p> <p>The care plans included, but were not limited to, "At times I may become agitated.....". The care plan lacked a plan of care pertaining to the use of an antipsychotic medication.</p> <p>On 9/24/14 at 4:33 p.m., the AIT (Administrator in Training) provided the "Executive Summary: Clinical Documentations Systems" policy. The policy indicated, "Subsequent team conferences shall be scheduled based on....condition changes, and resident needs with the care plans updated or initiated as indicated...."</p> <p>On 9/24/14 at 3:58 p.m., the Administrator indicated they had revised the care plan to address the use of the antipsychotic medication.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and</p>	F000282	F282Resident #7's MAR and	10/26/2014
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	<p>record review, the facility failed to ensure physician's orders were followed for 1 of 36 residents, in a total sample of 36 residents reviewed during Stage 2, in that, a medication was administered more times than it was ordered by the physician. (Resident #7)</p> <p>Findings include:</p> <p>On 9/22/14 at 3:36 p.m., LPN #1 was observed to administer medications to Resident #7. The medications included, but were not limited to, Flexeril 5 mg (milligrams), po (orally), tid (three times daily), prn (as needed), for muscle spasms.</p> <p>On 9/23/14 at 1:40 p.m., Resident #7's clinical record was reviewed. A telephone order, dated 9/17/14, indicated an order for Flexeril 5 mg, po, tid, prn for muscle spasms for 10 days. The "PRN Medication Tracking" located in the MAR (Medication Administration Record), indicated the Flexeril medication had been given four times per day on two separate days.</p> <p>On 9/24/14 at 4:16 p.m., the AIT (Administrator in Training) provided the, "Administration of PRN Medications Guideline" policy, undated. The policy included, but was not limited to, "prior to</p>		<p>physician orders were reviewed and staff that administer medication to her have been inserviced on these orders. Completion Date: 10/26/14 No other residents were affected by the deficient practice and through inservicing and alteration in documentation will ensure that PRN medications are administered as they are ordered. Completion Date: 10/26/14 Licensed nursing staff inserviced on proper PRN medication administration procedures. Completion Date: 10/26/14 DHS/designee will observe 3 PRN med tracking records per day for 2 weeks, then 3 per week for 3 months and 3 monthly thereafter for compliance with written physician orders. Pharmacist will also randomly observe PRN med tracking records during consult visit monthly with report on findings. Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter.</p>	

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F000309 SS=D	<p>administration of PRN medication the nurse shall review the physicians orders...."</p> <p>On 9/24/14 at 4:16 p.m., the AIT provided the "Medication Administrations Times Procedural Guidelines" policy. The policy indicated, "The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together".</p> <p>On 9/24/14 at 10:37 a.m., the "PRN Medication Tracking" form was reviewed with the Administrator. The Administrator indicated there could have been some documentation errors but it appeared the medication had been given too many times.</p> <p>3.1-35(g)(2)</p> <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 interview and record review,</p>	F000309	F309Resident #23 suffered no ill effects from the alleged deficient practice and will have an	10/26/2014			

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	<p>the facility failed to provide post dialysis assessments for 1 of 1 resident reviewed for dialysis and failed to ensure a resident who had a DNR (do not resuscitate) order did not receive CPR (cardiopulmonary resuscitation) in 1 of 3 residents reviewed for death, in that a dialysis shunt was not assessed and a resident who had a DNR order received CPR measures. (Resident # 23, Resident #22)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #23 was reviewed on 9/22/14 at 11:05 a.m. The clinical record indicated Resident #23 had a diagnoses including, but not limited to, end stage renal disease, dialysis, congestive heart failure, hypertension, non-Hodgkin's lymphoma, and coronary artery disease. The clinical record indicated Resident #23 was discharged from the facility on 9/21/14.</p> <p>A care plan, dated 8/6/14, indicated Resident #23 received hemodialysis. The care plan further indicated the AV thrill and bruit were to be accessed every shift.</p> <p>A physician's order, dated 7/23/14, indicated Resident #23 received dialysis on Tuesdays, Thursdays, and Saturdays.</p> <p>The "Renal Failure Skilled Charting</p>		<p>assessment of shunt done daily for bruit and thrill included. Completion Date: 10/26/14 Res #22 is deceased as stated in 2567 Any resident with an AV shunt has the potential to be affected by the alleged deficient practice and through corrective actions and inservicing will ensure residents are assessed at least daily according to policy. Residents with DNR status have the potential to be affected when carrying out their wishes and through corrective actions stated in F155 will ensure those are honored. Completion Date: 10/26/14 Systemic change is the documentation of bruit and thrill will be on MAR in addition to the opportunity on the daily skilled form to capture this. Completion Date: 10/26/14 Licensed nurses will be inserviced on expectation of assessment of shunts and DNR procedures. Completion Date: 10/26/14 DHS/designee will audit all dialysis residents MAR's daily x 30 days, weekly x 6 months and monthly thereafter to ensure that documentation and thorough assessment is completed. DHS will also review documentation of deaths daily to ensure CPR wishes were observed.</p>	

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	<p>Evaluation" indicated Resident #23 had a AV shunt in his upper right thigh. The "Renal Failure Skilled Charting Evaluation" indicated the thrill and bruit had not been checked on the following dates: 7/24/14, 7/25/14, 7/28/14, 7/29/14, 7/30/14, 8/2/14, 8/5/14, 8/6/14, 8/7/14, 8/8/14, 8/9/14/, 8/10/14, 8/11/14, 81214, 8/13/14, 8/14/14, 8/15/14, 8/16/14, 817/14, 8/20/14, 8/22/14, and 8/25/14.</p> <p>A nurse's note, dated 8/8/14 at 1:00 p.m., indicated Resident #23 had a fistulagram performed. The note further indicated the AV shunt was accessed, a blockage was noted and opened using a balloon technique, and the resident was sutured and a dressing was placed over the site.</p> <p>During an interview on 9/22/14 at 11:22 a.m., LPN #3 indicated the thrill and bruit should be checked every shift and recorded in the MAR (Medication Administration Record) or in the TAR (Treatment Administration Record.) LPN #3 further indicated the thrill and bruit should be recorded on the "Renal Failure Skilled Charting Evaluation" form. LPN #3 further questioned whether an AV shunt would have a thrill or bruit if it was in the thigh area of the leg.</p> <p>During an interview on 9/22/14 at 11:50</p>			

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	<p>a.m., RN #2 indicated the thrill and bruit should be documented in the TAR or on a "special" form the facility used, which the staff had not filled out or placed on the resident's chart.</p> <p>The "Guidelines for Monitoring Shunt: Hemodialysis Arteriovascular (AV) Access," dated January 2014, and obtained from the Administrator In Training on 9/24/14 at 4:16 p.m., indicated the AV shunt is to be monitored for thrill and bruit daily.</p> <p>2. The clinical record of Resident #22 was reviewed on 9/18/14 at 9:02 a.m. Resident #22 had a diagnosis including, but not limited to, dementia with psychotic features, coronary artery disease, status-post pacemaker insertion, organic brain syndrome, cardiomyopathy, sick sinus syndrome, and diabetes mellitus type two (2). The clinical record indicated Resident #22 had an advanced directive, signed by the physician on 7/31/13, for a do not resuscitate (DNR) order. Resident #22 expired on 9/7/14.</p> <p>A nurse's note, dated 9/7/14 at 5:20 p.m., indicated Resident #22 was found slumped over in a wheelchair in the dining room. Resident #22's apical pulse was found to be absent. After finger sweeping of Resident #22's mouth was</p>			

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	<p>completed and the Heimlich maneuver was attempted without success, the resident was wheeled to the resident's room and placed in bed on a back board with oxygen being started. Resident #22 vital signs continued to be absent.</p> <p>A nurse's notes, dated 9/7/14 at 5:23 p.m., indicated an emergency call was placed for the paramedics and cardiopulmonary resuscitation (CPR) was started per protocol. The police department arrived. The note indicated chest compressions were terminated after the DNR was reviewed.</p> <p>A nurse's note, dated 9/7/14 at 5:35 p.m., indicated paramedics arrived at the facility where the DNR status was reviewed.</p> <p>A nurse's note, dated 9/7/14 at 5:40 p.m., indicated the family, the physician, and the coroner were notified of Resident #22's death.</p> <p>During an interview on 9/24/14 at 2:45 p.m., RN #1 indicated the code status of the residents is located on the face sheet with the MAR (Medication Administration Record) book and is also in the resident's clinical record.</p> <p>The "Guidelines for DNR Orders,</p>			

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F000323 SS=D	<p>obtained from the Administrator In Training, on 9/24/14 at 4:16 p.m., indicated do not resuscitate orders will remain in effect until the resident (or legal surrogate) provided the campus with a signed and dated request to end the DNR order.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the residents were as free from accident hazards as possible, for 1 of 4 residents reviewed, in a sample of 30 that met the criteria, in that, fall prevention measures were not implemented and/or pressure alarms were not in place as ordered. (Resident A)</p> <p>Findings include:</p> <p>On 9/18/14 at 1:45 p.m., Resident A was observed in his wheelchair, no alarm was visible. Resident A indicated he was on his way to sit on the porch.</p> <p>On 9/18/14 at 2:25 p.m., Resident A was</p>	F000323	F323Resident A had pressure pad discontinued as stated in 2567 and his current plan of care has been reviewed with those that care for him.Completion Date: 10/26/14All residents with alarms have the potential to be affected and therefore have been assessed to ensure proper placement of alarms and inservicing of staff will ensure fall interventions remain in place as ordered.Completion Date: 10/26/14Nursing staff will be inserviced on proper alarm placement and fall interventions as well as required documentation when fall occur. Nurse managers and IDT team will be inserviced on fall documentation follow up and careplanning.Completion Date:	10/26/2014

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	<p>observed being escorted back to his room with a family member, no alarm was visible.</p> <p>On 9/22/14 at 10:15 a.m., Resident A was observed in bed. No pressure alarm was observed.</p> <p>On 9/18/14 at 10:24 a.m., Resident A's clinical record was reviewed. Resident A's was admitted 6/20/14. Resident A's diagnoses included, but were not limited to, rehab (rehabilitation), joint replacement, abnormal gait, weakness, and difficulty in walking.</p> <p>Resident A's care plans included, but were not limited to, at risk for falls, initiated 7/5/14. The interventions included, but were not limited to, floor mat alarm to floor next to the bed, initiated 7/23/14 and discontinued 8/18/14, and a pressure pad alarm to wheelchair and bed at all times, initiated 8/17/14.</p> <p>The most recent signed physician's recapitulation orders, signed 9/12/14, included, but were not limited to, pad alarm in bed/wheelchair at all times.</p> <p>The Nurse's Notes, dated 7/23/14 at 6:30 a.m., indicated the resident was found sitting on the floor.</p>		<p>10/26/14DHS/designee will monitor 3 alarms daily for proper placement x 2 weeks, 3 alarms per week x 3 months and 3 alarms per month thereafter. Fall documentation will be reviewed daily in clinical care meeting to ensure completeness of circumstance form including residents found on floor. Results of monitoring will be forwarded to QA committee monthly x 6 months for review and quarterly thereafter.</p>	

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	<p>The Nurse's Notes, dated 8/16/14 at 6:15 a.m., indicated, the resident's alarm sounded and the nurse and another staff member responded. The resident was found sitting on the floor mat alarm.</p> <p>The Nurse's Notes, dated 8/17/14 at 2:15 a.m., indicated, the resident was noted to be on the floor in the bathroom and the resident activated the emergency light. The note further indicated the resident had attempted to toilet self, fell while transferring, and hit his head on the toilet. A quarter sized abrasion was noted to his left temple. The note indicate neurological checks were initiated and were within normal limits. The note further indicated the physician was notified. A follow up note at 5:50 a.m., indicated the neurological checks were within normal limits.</p> <p>A Fall Circumstance, Assessment and Intervention form, dated 7/23/14 at 6:45 a.m., indicated the resident was found on the floor.</p> <p>A Fall Circumstance, Assessment and Intervention form, dated 8/17/14 at 2:00 a.m., indicated the resident was found on the floor in his bathroom. The form further indicated the resident received an injury to his left forehead. The other</p>			

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	<p>comments section indicated, "res (resident) took self to bathroom w/o (without) engaging floor alarm, fell in bathroom transferring self from toilet to w/c (wheelchair)".</p> <p>The record lacked a Fall Circumstance, Assessment and Intervention form, for the fall documented in the Nurse's Notes for 8/16/14.</p> <p>On 9/22/14 at 2:04 p.m., RN #1 was interviewed. RN #1 indicated Resident A had required alarms but therapy had agreed the alarms could be discontinued on that date (9/22/14).</p> <p>On 9/22/14 at 9:15 a.m., Resident A's clinical record was again reviewed. A Refusal of Care Concern Circumstance Investigation, dated 9/18/14 at 2:00 p.m., indicated the resident had refused the alarm. The form indicated the resident had received education of the purpose of the treatment and the consequences of the refusal. The prevention update area of the form was blank. The IDT (Interdisciplinary Team) review section of the form, dated 9/19/14, The IDT review of above prevention update agrees as appropriate to maximize safety indicated yes. The IDT review recommends the following change to prevention update was blank. The 72</p>			

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	<p>hour Follow up portion of the form indicated: 9/19/14 6:00 p.m. to 6 a.m.: Refusal/denial prevention interventions in place and effective 9/19/14 (no time) Refusal/denial prevention interventions in place and effective 9/19/14 (no time) Refusal/denial prevention interventions in place and effective</p> <p>The Nursing note, dated 9/18/14 at 2:15 p.m., indicated Resident A had been non compliant with the pressure pad alarm to the wheelchair. The note further indicated the resident refused to keep the alarm in the wheelchair and removed the alarm by himself and/or turned the alarm off.</p> <p>On 9/24/14 at 4:16 p.m., the AIT (Administrator in Training) provided the "Falls Management Program Guidelines" policy, dated 3/2008. The policy indicated, "...when a resident is found on the floor, a fall is considered to have occurred". The policy further indicated, "Care plan interventions should be implemented that address the resident's risk factors.....should a resident experience a fall the attending nurse shall complete the 'Fall Circumstance and Reassessment Form'....".</p>			

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F000329 SS=D	<p>This Federal tag relates to Complaint IN00154146</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 interview and record review, the facility failed to adequately monitor the use of an antihypertensive, for 1 of 5 residents, in a sample of 30 residents reviewed during stage 1, in that, blood pressures were not monitored. (Resident</p>	F000329	F329Resident A has current blood pressure and heart rate monitoring documented on MAR and licensed staff inserved on the requirement of obtaining at time of med administration to in turn determine if need to hold is present.Completion Date 10/26/14All residents receiving	10/26/2014

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	<p>A)</p> <p>Findings include:</p> <p>On 9/18/14 at 10:24 a.m., Resident A's clinical record was reviewed. Resident A's diagnoses included, but were not limited to hypertension and ischemic heart disease. The most recent signed physician's recapitulation orders, signed 9/17/14, included, but were not limited to: Metoprolol TRT (a medication used for the treatment of of high blood pressure and/or an irregular heart rate) 100 mg (milligrams), give 1 tablet, orally, once daily. A special note indicated to hold the medication for a SBP (Systolic Blood Pressure) less than 160 mm(millimeters)/Hg (Mercury) or a pulse less than 60 beats per minute.</p> <p>The Blood Pressure Log, dated September 2014, lacked any documented blood pressures.</p> <p>The MAR (Medication Administration Record), dated 9/5/14 through 9/30/14, lacked an assessed blood pressure on 9/5/14 though 9/13/14 and 9/15/14 through 9/17/14. The MAR lacked an assessed heart rate 9/5/14 through 9/8/14, 9/10/14 though 9/13/14, and 9/18/14.</p> <p>The care plans included, but were not</p>		<p>anti-hypertensive medications have the potential to be affected by the alleged deficient practice therefore DHS/designee have reviewed their medications and placed MAR documentation of blood pressures and heart rates to be obtained prior to their administration if necessary. Completion Date 10/26/14 Systemic change is that all residents who receive anti-hypertensive medications will have blood pressure and or heart rate obtained prior to administration if there are parameters to hold ordered by physician. Completion Date 10/26/14 DHS/Designee will monitor MAR five times per week for 30 days then weekly for 30 days to ensure blood pressure and heart rate is documented on MAR and orders are followed for administration based on them. Results from audit will be forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestion.</p>	

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F000332 SS=D	<p>limited to, check blood pressure every shift, initiated 7/14/14, and continue to monitor my blood pressure, undated.</p> <p>On 9/22/14 at 2:08 p.m., RN #1 indicated Resident A's blood pressure and heart rate should be assessed daily because the resident had medications with parameters. At that time, the blood pressure log and MAR (Medication Administration Record) for September was observed with RN #1. RN #1 acknowledged the blood pressures and heart rates had not been assessed.</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure it was free of medication error rates of five percent or greater, for 2 of 10 residents observed during medication administration, in that, 5 errors were made out of 31 opportunities for error, resulting in an error rate of 16.12 percent. One (1) of 6 licensed nurses and/or QMA (Qualified Medication Aid) observed</p>	F000332	F332Resident #155 suffered no ill effects from the alleged deficient practice and staff that administer medicine to for her have been inserviced on the requirement to administer the medicine with food as ordered.Completion Date 10/26/14Resident #7 suffered no ill effects from the alleged deficient practice and staff that administer medicine have been inserviced on the requirement to obtain blood pressure and heart rate, administer with food and	10/26/2014

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	<p>made errors. (Residents #7, Resident #155) (LPN #1)</p> <p>Findings include:</p> <p>1. On 9/22/14 at 3:28 p.m., LPN #1 was observed to administer medications to Resident #155. LPN #1 was observed to administer Coreg (a medication to treat high blood pressure and/or an irregular heart rate) 6.25 mg(milligrams) to Resident #155. No snack or food was observed to be given at the time the medication was administered.</p> <p>On 9/23/14 at 2:03 p.m., Resident #155's most recent signed physicians recapitulation orders, signed 9/18/14, were reviewed. The orders included, but were not limited to, Coreg 6.25 mg, one po (by mouth), bid (two times daily), with food.</p> <p>2. On 9/22/14 at 3:36 p.m., LPN #1 was observed to administer medications to Resident #7. LPN #1 was observed to administer the following medications: 2 units of Novolog (an injectable medication used for the treatment of high blood sugar) Flex Pen 3 ml (milliliters) for a blood sugar result of 166 ml/dl (deciliter) Coreg 3.125 mg Cozaar (a medication used for the</p>		<p>insulin to be given as ordered 30 minutes before meals. Completion Date 10/26/14 LPN #1 has completed medication administration course and will have a med pass observation completed. All other staff that pass meds will be inserviced. Completion Date 10/26/14 All residents receiving medication have the potential to be affected by the alleged deficient practice and through inservicing and observations will ensure medications are given as ordered. Completion Date 10/26/14 DHS/designee will: perform 3 random medication pass audits monthly for 6 months and then quarterly, continue with pharmacist audits every 60 days. Results of audits will be forwarded to QA committee monthly x 6 months and then quarterly for review and further suggestions.</p>	

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	<p>treatment of high blood pressure) 25 mg Simvastatin (a medication used for the treatment of high cholesterol) 40 mg</p> <p>No snack or food products were observed to be given at that time. No blood pressure and/or heart rate was observed to be assessed at that time.</p> <p>On 9/23/14 at 1:40 p.m., Resident #7's most recent signed physician's recapitulation orders, signed 9/17/14, were reviewed. The orders included, but were not limited to: "Cozaar 25 mg, give one tablet, orally, once a day with supper, and a special note to hold the medication for a SBP (Systolic Blood Pressure) below 100 mm(millimeters)/Hg (mercury) Coreg 3.125 mg, give one tablet, orally, twice daily, and a special note to hold the medication for a SBP less than 100 mm/Hg and/or a heart rate below 55 bpm (beats per minute) Simvastatin 40 mg, give one table, orally, once a day, with supper Novolog Flex Pen 3ml syrin (syringe) accu chk (blood glucose test)...141-180=2 units...given at hs (before bed), 6:00 a.m., 11:30 a.m., and 4:30 p.m."</p> <p>Dinner was served at 5:00 p.m.</p>			

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F000333 SS=D	<p>On 9/24/14 at 4:16 p.m., the AIT (Administrator in Training) provided the "Medications Administration Times Procedural Guidelines" policy. The policy indicated, "Medications that have been ordered at specific time shall be administered at the time designated by the attending physician....Medications that are to be received prior to, with, or after meals shall be administered at these times".</p> <p>On 9/24/14 at 2:42 p.m., RN #1 indicated insulin should not be given more than 30 minutes prior to the meal. RN #1 further indicated if a medication is ordered with food, a snack should be provided or it should be administered right before the meal policy</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors, in that, Lovenox was administered prior to</p>	F000333	F333Resident A's medication error was documented as stated and physician was notified, he had surgery as planned and has current medications being administered as ordered.Completion Date	10/26/2014			

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	<p>surgery for 1 of 5 residents reviewed for medications. (Resident A)</p> <p>Findings include:</p> <p>On 9/18/14 at 10:24 a.m., Resident A's clinical record was reviewed.</p> <p>A physician,s telephone order, dated 6/26/14, included, but was not limited to, for same day surgery on Monday June 30, hold Lovenox (a medication used to thin the blood).</p> <p>The MAR (Medication Administration Record), dated 6/20/14 through 6/30/14, indicated Lovenox had been given upon rising on 6/30/14.</p> <p>On 9/23/14 at 8:37 a.m., hospital records were reviewed. An Admission Form, dated 6/30/14, indicated Resident A's surgery had been cancelled.</p> <p>On 9/24/14 at 10:37 a.m., the Administrator indicated a medication error had occurred and the Lovenox had been given prior to the resident leaving for surgery the morning of 6/30/14.</p> <p>This Federal tag relates to Complaint IN00154146</p> <p>3.1-25(b)(9)</p>		<p>10/26/14All residents receiving medication have the potential to be affected by the alleged deficient practice and through inservicing and observations as stated in F332 of random med pass audits will ensure medications are given as ordered.Completion Date 10/26/14DHS/designee will: perform 3 random medication pass audits monthly for 6 months and then quarterly, review prescribed orders for accuracy daily for 2 weeks then one time weekly for one month then continue with monthly recap order review and pharmacist audits every 60 days.Results of audits will be forwarded to QA committee monthly x 6 months and then quarterly for review and further suggestion.</p>				

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F000441 SS=D	<p>3.1-48(c)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			
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	<p>Based on observation, interview, and record review, the facility failed to ensure gloves were used to prevent the spread of infections and/or hand hygiene was performed, in that, injections were administrated without glove use or hand hygiene for 3 of 6 residents observed during care. (Resident #155, Resident #7, Resident #58)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 9/22/14 at 3:32 p.m., LPN #1 entered Resident #155's room to assess his blood sugar. LPN #1 was observed to cleanse the residents finger, applied a needle stick to the finger, and assessed the blood sugar with the glucometer (a machine used to measure blood sugar). There was not any hand hygiene and/or glove application observed prior to the needle stick.</li> <li>On 9/22/14 at 3:38 a.m., LPN #1 was observed to assess Resident #7's blood sugar level. LPN #1 was observed to cleanse the residents finger, applied a needle stick to the finger, and assessed the blood sugar with the glucometer. No gloves were applied. LPN #1 was observed to prepare Resident #7's insulin (an injectable medication used to treat high blood sugar) and administer the</li> </ol>	F000441	<p>F441Resident #155, #7, and #58 suffered no ill effects from the findings on the 2567 related to hand hygiene.Completion Date 10/26/14LPN #1 and LPN #3 will complete infection control course to ensure that resident care and handwshing procedures are carried out to prevent possible contamination and spread of infection.Completion Date 10/26/14All residents have the potential to be affected by the alleged defcient practice and through altercations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed.Completion Date 10/26/14Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent spreading of infection with a focus on medication procedures.Completion Date 10/26/14DHS/designee will monitor resident care that includes handwashing/glove usage during med pass 5 x week for 3 weeks, 3 x week for 2 months and then 3 random times monthly.Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p>	10/26/2014

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	<p>insulin. No gloves were applied. LPN #1 was then observed to lick her thumb in order to turn the page of the MAR (Medication Administration Record). LPN #1 proceeded to set up the rest of Resident #7's medications by placing them in her bare hand and then placing them in the medication cup.</p> <p>3. On 9/23/14 at 11:53 a.m., LPN #3 was observed to prepare to administer insulin to Resident #58. LPN #3 was observed to enter the resident's room and administer the insulin. No gloves were applied. LPN #3 was queried regarding the use of gloves and injectable medications. LPN #3 indicated that since the medication was an insulin pen, gloves were optional.</p> <p>On 9/22/14 at 3:48 p.m., LPN #1 indicated hands should be sanitized between every resident.</p> <p>On 9/24/14 at 8:25 a.m., LPN #4 was interviewed. LPN #4 indicated gloves should be worn if there is the potential to come into contact with body fluids, such as eye drops and insulin.</p> <p>On 9/23/14 at 2:00 p.m., the Administrator provided the "Guidelines for Handwashing" policy, dated 10/2004. The policy included, but was not limited</p>			

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F000463 SS=D	<p>to, "Health Care Workers shall wash hands at times such as...before/after having direct physical contact with residents".</p> <p>On 9/23/14 at 2:00 p.m., the Administrator provided the "Guidelines: Standard Precautions" policy, dated 1/2010. The policy indicated, "Gloves...wear when hand contact is reasonably anticipated with resident's mucous membrane, non-intact skin, and/or body substances or items...".</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to provide a functioning call light to 1 of 30 residents reviewed, in that the call light was not working on 2 (two separate occasions) in a resident's room. (Room 326 B)</p> <p>Findings include:</p> <p>Room # 326 was observed on 9/17/14 at</p>	F000463	F463The call light for room 326B was fixed as stated in the 2567 and no residents were affected.Completion Date 9-25-14All call lights were checked for proper functioning.Completion Date 10/26/14Systemic change is that call lights will be placed on preventive maintenance log for routine checks.Completion Date 10/26/14Director of Plant Operations will monitor resident	10/26/2014

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F000465 SS=E	<p>9:20 a.m. The call light for bed B was non-functioning. The call light was non-functioning again on 9/23/14 at 2:20 p.m.</p> <p>During an interview on 9/23/14 at 2:20 p.m., CNA #2 indicated she thought the call light had been fixed. She further indicated she would stay in the room with the resident until the maintenance department repaired the call light.</p> <p>During an interview on 9/25/14 at 8:03 a.m., CNA #2 indicated the call light had been repaired.</p> <p>During an observation on 9/25/14 at 1:57 p.m., the call light for room 326 B was observed to be working.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a functional, sanitary, and comfortable environment for residents, staff, and public, for 8 of 28 resident rooms observed, 1 of 4 units clean utility rooms observed, and 3 of 30</p>	F000465	<p>call lights and bulbs weekly x 2 weeks and monthly thereafter. Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestion/comments</p> <p>F465 There were no residents, visitors and/or staff that were affected by the alleged deficient practice of not personalizing items, wheelchair arms cracked, cracked fall mat pads, marred walls, chipped/discolored caulking, loose trim or gap in the floor between shower and</p>	10/26/2014

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	<p>residents observed, in that wheelchair arms were cracked, floor fall pads were cracked, walls were marred, caulking was chipped and discolored, a toothbrush had no name on it, trim was loose from the commode grab bar, and there was a gap between the bathroom floor and the shower with no cover for it. (Rooms 309, 310, 314, 322, 602, 604, 606, Resident #269, #57, #61, Unit 300)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Room 309 was observed on 9/17/14 at 9:10 a.m. A toothbrush which was in a baggy was observed in the bathroom sink with no name on it.</li> <li>Room 314 was observed on 9/17/14 at 8:51 a.m. The radiator had black marks on it and there were scuff marks on the bathroom door and frame. The same were observed on 9/23/14 at 11:16 a.m.</li> <li>Room 310 was observed on 9/17/14 at 9:35 a.m. The radiator had black scuff marks on it. The same was observed on 9/23/14 at 11:14 a.m.</li> <li>Room 322 was observed on 9/17/14 at 1:42 p.m. The wall around the sink had chipped paint. The wall to the left of the bathroom door was chipped and there was a crack between the shower and the</li> </ol>		<p>bathroom floor or utility room door lock not functioning properly. Completion Date 10/26/14 Through inservicing to Environmental, plant operations, staffing coordinator and nursing staff will ensure that a safe, functional, sanitary and comfortable environment is in place. Completion Date 10/26/14 Systemic Changes will be: Director of Plant Operations will be inserviced to add to his preventive room maintenance forms to add the checking of flooring, all caulking and paint/trim in both bathroom and residents room. DPO will also check the function of the lock on the utility room door 3 x week for 2 weeks then weekly for 1 month and the monthly thereafter. Completion Date 10/26/14 Staffing Coordinator will be inserviced to audit all wheelchairs along with fall floor mats monthly and change out as needed. Completion Date 10/26/14 Environmental department will be inserviced along with the additions of checking paint/trim to the deep clean room audit form. Completion Date 10/26/14 Nursing staff will be inserviced to personalize all hygiene items when 2 residents share a semi-private room. DHS/designee will perform audits 3 x week for 2 weeks then weekly for 1 month and then monthly thereafter. Completion Date 10/26/14 All results will be brought</p>				

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	<p>floor. It was the same on 9/23/14 at 11:20 a.m.</p> <p>5. Room 604 was observed on 9/17/14 at 9:51 a.m., to have a non-functioning air conditioner/heater unit.</p> <p>7. Room 606 was observed on 9/17/14 at 9:12 a.m. There was a gap between the shower and the floor with no covering on it and the caulking around the commode base was brown. It was the same on 9/23/14 at 11:25 a.m.</p> <p>8. Room 615 was observed on 9/17/14 at 11:02 a.m. Caulking was missing between the shower floor and the bathroom floor. The caulking and paint were cracked around the sink. It was the same on 9/23/14 at 11:46 a.m.</p> <p>9. Resident #57's wheelchair was observed on 9/17/14 at 9:10 a.m. The arms of the wheelchair had cracks on them. The same was observed on 9/23/14 at 9:13 a.m.</p> <p>10. Resident #61's wheelchair was observed on 9/17/14 at 8:51 a.m. The arms of the wheelchair had cracks on them. The same was observed on</p>		to the QA committee monthly for further review and recommendations.		

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	<p>9/23/14 at 11:16 a.m.</p> <p>11. Resident #61's fall floor mat was observed on 9/17/14 at 9:35 a.m. The mat had cracks around the outside edges. The same was observed on 9/23/14 at 11:14 a.m.</p> <p>12. During an interview on 9/15/14 at 12:57 p.m., Housekeeper #1 indicated whenever a housekeeper would discovered chipped paint or marred walls they would notify the maintenance department. Housekeeper #1 indicated she did not know if the maintenance department had a routine schedule for painting or caulking in the resident's rooms.</p> <p>13. The "Environmental Policy and Procedures for Room Cleaning" was obtained from the Administrator In Training on 9/24/14 at 4:16 p.m. The policy indicated room cleanliness is the top priority of the Environmental Services department. The policy further indicated the rooms and restrooms were to be cleaned daily.</p> <p>During initial tour of the facility on</p>			

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	<p>9/16/14 at 12:16 p.m., the door to the soiled utility room, on the 300 unit. was found to be open. The door has a keypad on the outside. The following items were found in the cabinets:</p> <p>14. 1 box Cascade,(dishwashing powder) -with the warning label that indicated: do not get on skin or clothing-keep out of reach of children.</p> <p>15. A 48 ounce bottle of Lysol Multi Surface Cleaner, with the warning label that indicated: causes moderate eye irritation, avoid contact with eyes, clothing and skin, hazardous to humans and animals.</p> <p>16. A bottle of Clorox Bleach Germicidal Cleaner. with a warning label that indicated: keep out of reach of children-Hazardous to humans and animals. Avoid contact with eyes or clothing.</p> <p>17. A 32 ounce bottle of ALL (laundry detergent ) with a warning label that indicated: caution eye irritant. May be harmful if swallowed. If swallowed, drink glass of water and call physician immediately. Keep out of reach of children.</p> <p>18. A bottle of Antibacterial All Purpose Cleaner with a warning label which</p>			

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	<p>indicated : Keep out of reach of children. Hazardous to humans and animals, causes mild eye irritation.</p> <p>19. A bottle of Oxivir Five - 16 Concentrate with a warning label which indicated - cleanser for beds and equipment- Keep out of reach of children, for commercial or industrial use.</p> <p>20. A bottle of Lime Away Stain Remover with a warning label which indicated: Keep out of reach of children. Danger can cause respiratory tract,eye and skinburns- harmful if swallowed.- get medical attention immediately.</p> <p>21. A red needle box on the counter, with old needles in it.</p> <p>22. On 9/18/14 at 9:04 a.m. the soiled utility room door, on 300 unit, was unlocked. On 9/22/14 the door to soiled utility room, on the 300 unit, was unlocked.</p> <p>23. On 9/24/14 at 3:05 p.m. the Administrator indicated the door of the soiled utility room should be locked and the batteries for the keypad control on outside of door may need to be changed or the door closing hinge may need to be fixed.</p>						

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R000000	<p>On 9/24/14 at 4:06 p.m. the Administrator stated there is no policy for keeping utility doors locked or schedule to check the locks.</p> <p>3.1-19(f) 3.1-19(j)</p>	R000000		
R000214	<p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a substantial change in a resident's condition was evaluated in a timely manner, for 1 of 1 resident reviewed for pressure sores, in the total sample of 7, in that pressure sores were found on bilateral heels that were unstageable at the time of discovery. (Resident # 157)</p>	R000214	<p>R214 All residential residents have the potential to be affected by the alleged deficient practices and with inservicing and training of staff will ensure proper assessment is practiced. Completion Date 10/26/14 Systemic change will be that nursing staff will be inserviced to report any pressure/stasis areas to a licensed nursing staff member to</p>	10/26/2014

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	<p>Finding includes:</p> <p>Resident #157's record was reviewed on 9/24/14 at 1:20 p.m. The resident was admitted to the facility 8/26/14 with diagnoses including, but not limited to, weakness, history of head injury, prostate cancer, and hypertension.</p> <p>The resident's most recent evaluation and service plan, dated 8/27/14, indicated he was alert and needed assistance with mobility via wheelchair, and with hygiene.</p> <p>The resident had a change in condition form, dated 9/19/14 at 9:00 a.m., indicating a right heel pressure area had been found.</p> <p>The pressure sore assessment indicated it was stage "E" (eschar), "color purple, surrounding tissue pink, 2.5 centimeters (cm) by 2 cm by ? depth."</p> <p>A second change of condition form was dated 9/20/14 at 10:15 a.m.</p> <p>The pressure ulcer assessment for the second area, dated 9/20/14, indicated there was an area on the left heel. The stage was identified as "E," "the color was dark purple with surrounding tissue red." The left heel area was measured at "5.5 cm by 4.5 cm by ? depth."</p> <p>There was a physician's order, dated 9/19/14 for "skin prep q [every] shift (R)</p>		<p>whom then will complete a full body skin assessment and then notify the wound nurse.</p> <p>Completion Date 10/26/14 All pressure/stasis areas will be reviewed weekly by the wound nurse and discussed during weekly Clinical At Risk meeting and then brought forward to the QA committee monthly for further review and recommendations if required.</p>	

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	<p>[right] outer heel until healed." The order indicated it was for an unstageable area and included bilateral heel protectors to be placed at bedtime. A new order, dated 9/20/14, indicated the use of skin prep to bilateral heels every shift.</p> <p>LPN #2 was interviewed on 9/24/14 at 1:45 p.m. She indicated a CNA had called her in to look at the resident's right heel on "Saturday." She indicated the resident's sock and shoe were already on the left foot, so she assumed the left foot was okay since the CNA hadn't mentioned it. She further indicated that on Sunday, she decided she should take a look at the left heel and found the area on that heel.</p> <p>On 9/24/14 at 2:35 p.m., Resident #157 was observed. He was positioned in a wheelchair. The right heel area was 2.5 cm by 2.5 cm by undetermined depth, dark purple/whitish surface, unstageable, with distinct edges. The left heel was 5.5 cm by 4.5 cm by undetermined depth, dark purple whitish surface with surrounding tissue that was reddened.</p>				