

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/01/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F000000	<p>This survey was for a Recertification and State Licensure survey.</p> <p>Survey Dates: 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/31/14, and 4/1/14.</p> <p>Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440</p> <p>Survey Team: Barbara Fowler RN TC Diane Hancock RN Denise Schwandner RN</p> <p>Census Bed Type: SNF/NF: 70 Total: 70</p> <p>Census Payor Type: Medicare: 13 Medicaid: 44 Other: 13 Total: 70</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.3.</p> <p>Quality review completed on April 4, 2014 by Jodi Meyer, RN 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the</p>	F000000	We are requesting a desk review. Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.	
F000159 SS=B	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.3.</p> <p>Quality review completed on April 4, 2014 by Jodi Meyer, RN 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the</p>			

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

TITLE

(X6) DATE

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

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	<p>resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other</p>			

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	<p>nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure resident funds were available at all times, including weekends and evenings, for 4 of 20 residents interviewed during Stage 1, in that residents indicated money was only available during the day on Monday through Friday. (Residents #13, #44, #57, #51)</p> <p>Finding includes:</p> <p>The following residents were interviewed and indicated they were unable to access resident funds in the evenings or on weekends: Resident #123 interviewed on 3/25/14 at 10:43 a.m. Resident #124 interviewed on 3/25/14 at 2:05 p.m. Resident #125 interviewed on 3/25/14 at 10:27 a.m. Resident #126 interviewed on 3/24/14 at 11:42 a.m.</p> <p>The Business Office Manager was interviewed on 3/26/14 at 2:55 p.m. She indicated banking hours were 8 to 4:30 p.m. Monday through Friday and residents did not have access to funds outside of those hours.</p> <p>A policy and procedure was requested from the Administrator and Business Office Manager on 3/31/14 at 3:00 p.m. An administrative policy was received from the Administrator on 3/31/14 at 3:10 p.m. The policy and procedure included, but was not limited to, the following: "...Upon receiving written authorization from a</p>	F000159	<p>We are requesting a desk review.F 159 Facility Management of Personal Funds The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit resident mistreatment, neglect and abuse of residents and misappropriation of resident property. A. <b>ACTIONS TAKEN:</b> 1. Residents 13,14,57,51 were advised that resident's funds are now available Monday-Sunday. B. <b>OTHERS IDENTIFIED:</b> 1. All resident's had the potential to be affected and have been advised that funds are now available Monday-Sunday. C. <b>MEASURES TAKEN:</b> 1. An In-service was completed with the Business Office staff members on the Policy and Procedure for Resident Funds. 2. A letter was provided to all residents and mailed to the families advising that resident's funds are now available Monday thru Sunday. 3. Resident Council was held on_04/16/2014_ advising them of the procedure for availability of residents funds Monday thru Sunday and banking hours. D. <b>HOW MONITORED:</b> 1. At the monthly Resident Council meeting residents will be asked for feedback on the availability of resident funds. 2. The Administrator will review results of</p>	04/23/2014			

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F000160 SS=B	<p>resident or responsible party, the facility must hold, safeguard and manage an account for the personal funds of a resident. These funds must be reasonably accessible to the resident."</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on record review and interview, the facility failed to ensure personal funds were conveyed to the appropriate persons and/or authorities upon death or discharge, for 2 of 2 residents with funds deposited with the facility, out of 59 residents with funds managed by the facility. (Residents #127, 128)</p> <p>Finding includes:</p> <p>A list of 59 residents with funds managed by the facility was provided by the Business Office Manager on 3/26/14 at 2:00 p.m. The list was reviewed with the Business Office manager on 3/26/14 at 2:55 p.m. Two residents had funds listed as follows: Resident #127 had \$1,156.39 in an account. Resident #128 had \$2,673.68 in an account.</p> <p>According to the Business Office Manager, Resident #127 discharged from the facility on</p>	F000160	<p>the resident council meeting for additional follow up. Any inconsistencies will be immediately clarified and corrected appropriately. Results will be monitored and reviews at the monthly QA meeting for determination of ongoing monitoring.</p> <p><u>We are requesting a desk review.F 160 Conveyance of Personal Funds upon death</u> The facility's intent is to comply with the federal requirement to upon the death of a resident with a personal fund within facility to disburse funds within 30 days to the resident estate. A. <b>ACTIONS TAKEN:</b> 1. Resident's # 127 and #128 personal funds have been disbursed to personal estates. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit was completed at the time of the Occurrence. No other residents were affected. C. <b>MEASURES TAKEN:</b> 1. Business Office manager will be educated on the facility policy regarding 30-day disbursement of personal funds upon death or discharge to the appropriate party. D. <b>HOW MONITORED:</b> 1. During the</p>	

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F000272 SS=D	<p>9/10/13 due to death. Resident #128 had discharged from the facility on 3/28/13 to the hospital or another facility.</p> <p>The Administrator indicated, on 3/26/14 at 3:05 p.m., disposition of the funds should have been completed upon or soon after discharge.</p> <p>The Delegation of Responsibility for the Management of Personal Funds was provided by the Director of Nurses on 3/31/14 at 3:10 p.m. Terms of Agreement included, but was not limited to, "...Upon termination all monies in the account, less charges, with any accumulated interest will be paid to the resident, the state or designated authorized party as appropriate within a reasonable timeframe."</p> <p>3.1-6(h) 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;</p>		<p>monthly QA meeting all discharged resident's personal funds accounts will be reviewed for proper disbursement. Any inconsistent results will be immediately clarified and corrected appropriately. Monitoring will be ongoing.</p>	

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	<p>Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to provide an accurate MDS (Minimum Data Set) assessment for 1 of 37 residents whose MDS assessments were reviewed. (Resident #16)</p> <p>Findings include:</p> <p>During an observation on 3/24/14 at 11:35 a.m., Resident #16 was observed to be sitting in a wheelchair with a contracture of the right hand and fingers. No splint was in place. Resident #16 was observed again on 3/26/14 at 10:05 a.m. and 3/27/14 at 9:25 a.m. with no splint in place.</p> <p>The clinical record of Resident #16 was reviewed on 3/26/14 at 3:15 p.m. The clinical record indicated Resident #16 had diagnoses including, but not limited to, cerebral vascular disease and hemiplegia. The MDS (Minimum Data Set) assessment indicated Resident #16 had a BIMS (Brief Interview for Mental Status) score of 14, which indicated</p>	F000272	<p>We are requesting a desk review. <u>F 272 Comprehensive Assessments</u> The facility's intent is to comply with the federal requirements to develop and implement written policies and procedures that conduct initial and periodic comprehensive, accurate, standardized reproducible assessment of each of resident's functional capacities.</p> <p>A. <b>ACTION TAKEN:</b> Resident #16 MDS was modified to accurately reflect her restorative program. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit was completed and no other residents were affected. C. <b>MEASURES TAKEN:</b> 1. MDS coordinator was in serviced on proper coding of MDS and appropriate documentation to reflect correctly. D. <b>HOW MONITORED:</b> 1. MDS Coordinator will audit all assessments related to restorative 1 time a week for the</p>	04/23/2014

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F000279 SS=E	<p>very slight cognitive impairment. The MDS indicated Resident #16 was not on a restorative program.</p> <p>During an interview on 3/31/14 at 9:20 a.m., the MDS Coordinator indicated a note had not been documented prior to the MDS being completed. The MDS Coordinator indicated she was responsible for documenting the note but had not done it. The MDS Coordinator therefore indicated the MDS was incorrectly marked for a restorative program.</p> <p>3.1-31(c)(11) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record</p>	F000279	<p>prior weeks completed assessments for accuracy. 2. The Administrator will review the results and any inconsistencies will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.</p> <p>We are requesting a desk review. <u>F 279 Develop Comprehensive Care plans</u> The facility's intent is to comply with</p>		

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	<p>review, the facility failed to ensure comprehensive care plans were developed for 5 of 37 Stage 2 sampled residents, in that care plans were not developed for oral/dental care, pressure ulcer prevention, restorative nursing, psychoactive medications, and pain management. (Residents #57, #85, #45, #87, #32)</p> <p>Findings include:</p> <p>1. During an observation on 3/25/14 at 10:25 a.m., Resident #57 was observed to be sitting in a wheelchair in her room. Resident #57 was observed to only be able to open her mouth slightly.</p> <p>The clinical record of Resident #57 was reviewed on 3/26/14 at 2:17 p.m. Resident #57 had diagnoses including, but not limited to, cerebral vascular disease, hypertension, anxiety, and depressive disorder. The MDS (Minimum Data Set) assessment, dated 8/2/13, indicated the resident had mouth/facial pain, and discomfort or difficulty with chewing. A BIMS (Brief Interview for Mental Status), dated 1/21/14, indicated Resident #57 had no cognitive impairment.</p> <p>During an interview on 3/25/14 at 10:27 a.m., Resident #57 indicated she was only able to open her mouth very slightly since having had a stroke.</p> <p>The clinical record lacked any documentation of a care plan for dental status.</p> <p>During an interview on 3/31/14 at 9:08 a.m., the ADoN (Assistant Director of Nursing) indicated she did not know why Resident #57 did not have a dental care plan as the resident was not able to open her mouth very</p>		<p>the federal requirements to maintain and develop comprehensive care plans that includes measureable objectives and time tables to meet a resident's medical nursing mental and psychosocial needs <b>A. ACTION TAKEN:</b> 1. Resident's #85 no longer resides in facility. Care plan initiated for Residents #57 to reflect difficulty opening mouth. Care plan initiated for Residents # 45 to reflect restorative program. Resident # 87 care plan initiated to reflect antipsychotic medication. Resident # 32 assessed and a care plan updated to reflect pain. <b>B. OTHERS IDENTIFIED:</b> 1. 100% audit was completed of current residents for accurate care plans. No residents with negative findings were found. <b>C. MEASURES TAKEN:</b> 1. During CQI meetings 5 times weekly IDT team will review any new admits and or new orders and care plans will be initiated accordingly. 2. During the Quarterly care plan meeting resident's plan of care will be reviewed and updated as appropriate. <b>D. HOW MONITORED:</b> 1. MDS Coordinator will validate care plans have been reviewed by the IDT team when completing the Quarterly care plan review. 2. The Administrator will review the results of the CQI minutes weekly and any inconsistent results will</p>	

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	<p>far and had difficulty with chewing.</p> <p>A policy, dated 7/1/11, indicated the Plan of Care was to be reviewed at least quarterly with each department's notes to reflect a review of all appropriate care plan goals and approaches. The policy indicated a comprehensive care plan must be developed within 7 (seven) days after the completion of the comprehensive assessment.</p> <p>2. Resident #85's clinical record was reviewed on 3/27/14 at 10:05 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, atrial fibrillation, heart failure, depression, history of leukemia, and hypertension.</p> <p>The resident's admission Minimum Data Set (MDS) assessment, dated 9/19/13, indicated the resident had no pressure ulcers, but was at risk for developing pressure ulcers. The resident required extensive assist of one person for transfers and limited assist of one person for ambulation at that time.</p> <p>There was no care plan addressing prevention of pressure ulcers.</p> <p>3. Resident #45's clinical record was reviewed on 3/26/14 at 9:49 a.m. She was admitted to the facility on 2/14/11 with diagnoses including, but not limited to, cerebrovascular disease, dementia, anxiety, depression, reflux, anemia, osteoarthritis, muscle weakness, osteoporosis, and hypertension.</p>		<p>be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing review.</p>	

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	<p>A 5-day Minimum Data Set (MDS) assessment, dated 12/4/13, indicated the resident required extensive assistance of 2 staff for transfers.</p> <p>On 3/26/14 at 10:25 a.m., the resident was observed to need moderate assist of two for a transfer. She did bear weight but just pivoted.</p> <p>A physical therapy discharge summary, dated 2/5/14, indicated the resident was discontinued due to a plateau in progress. The discharge recommendations included, "...continue CNA performing BLE [bilateral lower extremities] AAROM [active assisted range of motion] focusing on maintaining RLE [right lower extremity] hip and knee extension ROM [range of motion] and restorative group exercise class."</p> <p>There was no care plan in place to address active assisted range of motion, the right lower extremity, or restorative group exercise.</p> <p>4. The initial clinical record for Resident #87 was reviewed on 3/25/14 at 9:53 a.m. Resident #57 was noted to be receiving an antidepressant, an anti-anxiety medication, and an antipsychotic medication.</p> <p>Further record review on 3/26/14 at 8:54 a.m. indicated Resident #87 was admitted to the facility on 1/24/14 with diagnoses including, but not limited to, vascular dementia, hyperlipidemia, vitamin D deficiency, and scoliosis.</p> <p>Physician's orders dated 3/13/14 indicated a new order to begin the resident on Seroquel (antipsychotic medication) 50 milligrams one</p>			

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	<p>tablet by mouth at bedtime for unspecified psychosis/sundowning.</p> <p>No care plan had been initiated for the use of an antipsychotic medication. Interview with the Director of Nurses on 3/31/14 at 9:39 a.m. indicated there should have been a care plan for the use of the antipsychotic and there was not one in place.</p> <p>5. The medical record of Resident #32 was reviewed on 3/27/14 at 1:51 p.m. The record indicated the diagnoses of Resident #32 included, but was not limited to, anxiety state, convulsions, alcohol induced dementia, hypothyroidism, esophageal reflux, hypertension, anemia, depressive disorder, lack of coordination, and fall with a fracture of the left arm.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 9/30/13 indicated the resident had received pain medications, received non-medication for pain, the resident had pain in the last 5 days, the resident had pain frequently in the last 5 days, and the resident verbalized moderate pain in the last 5 days. The resident's Brief Interview for Mental Status score was 7 out of 15 indicating moderate cognitive impairment.</p> <p>The most recent Quarterly MDS dated 2/13/14 indicated the resident had received PRN pain medications or was offered and declined, the resident had pain in the last 5 days, the resident had occasional pain or hurting over the last 5 days, and the resident had mild pain in the last 5 days.</p>			

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F000309 SS=D	<p>The medical record failed to reveal a care plan for pain.</p> <p>In an interview with Resident #32 on 3/25/14 at 9:30 a.m., she indicated that she has pain without relief.</p> <p>In an interview with the DoN (Director of Nursing) on 3/31/14 at 10:10 a.m., she indicated that she was unable to find a care plan for pain.</p> <p>3.1-35(a) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, observation, and interview, the facility failed to provide care and services to 2 of 2 sampled residents with portacaths (implanted intravenous access) and 1 of 3 residents sampled for pain management, in the Stage 2 sample of 37, in that the portacaths were not flushed and pain was not managed. (Resident #13, Resident # 51, Resident #32)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #51 was reviewed on 3/26/14 at 9:50 a.m. Resident #51 had diagnoses including, but not limited</p>	F000309	<p>We are requesting a desk review. <u>F 309 Provide care services for highest well being</u> The facility's intent is to comply with the federal requirement to provide the necessary care and services to attain or maintain the highest practical physical mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. . A. <b>ACTIONS TAKEN:</b> 1. Resident's # 51 and # 13 care was completed immediately. The care plans and orders were clarified. 2. Resident # 32 pain care plan in place, pain assessment done 2-11-2014 and</p>	

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	<p>to, adenocarcinoma of the colon and anemia. The clinical record indicated Resident #51 had a portacath (an implanted appliance) present in the right upper chest. An MDS (Minimum Data Set) assessment indicated Resident #51 had no cognitive impairment. A form for care of the portacath, in the clinical record, indicated Resident #51 was to have the portacath flushed with 5 (five) ml (milliliters) of heparinized saline every 4 weeks when the portacath was not in use.</p> <p>A care plan, dated 3/20/14, indicated the resident had an implanted portacath. The care plan indicated the portacath was to be flushed according to the physician's orders and observed for any redness or edema.</p> <p>A MAR (Medication Administration Record), dated 1/1/14 - 1/31/14, indicated no care or assessment had been performed to the portacath.</p> <p>A MAR, dated 2/1/14 - 2/28/14, indicated no care or assessment had been performed for the portacath.</p> <p>A MAR, dated 3/1/14 - 3/31/14, indicated no care or assessment had been performed from 3/1/14 - 3/27/14 for the portacath.</p> <p>The clinical record lacked any documentation of the portacath being flushed or assessed.</p> <p>During an observation on 3/27/14 at 9:30 a.m., Resident #51 was observed to have a portacath in the right upper chest. Resident #51 indicated the facility had not provided any care to the port for at least 3 months.</p> <p>During an interview on 3/27/14 at 9:30 a.m., LPN #1 indicated portacaths needed to be</p>		<p>will continue to be completed quarterly and PRN. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit completed. No other residents were affected. C. <b>MEASURES TAKEN:</b> 1. Nurses were in serviced on documentation, care plans, pain management and care of ports. 2. All new orders/assessments will be reviewed in the daily CQI meeting for ongoing follow-up and management. D. <b>HOW MONITORED:</b> 1. DON/Designee will audit the plan of care of residents with ports on a weekly basis related to the plan of care. 2. DON/Designee will monitor the MAR for pain management and documentation 3 times per week for 4 weeks. Any negative findings will be immediately addressed. Monitoring will continue at least once weekly thereafter. 3. The Administrator will review the results of the audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.</p>				

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	<p>flushed daily when accessed. LPN #1 indicated only the RNs were allowed to access portacaths and flush them</p> <p>During an interview on 3/27/14 at 9:55 a.m., the DoN (Director of Nursing) indicated the RNs (Registered Nurses) on the unit should have flushed Resident #51's portacath as indicated on the form.</p> <p>2. Resident #13's clinical record was reviewed on 3/26/14 at 9:57 a.m. Resident #13 had diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease. An annual MDS (Minimum Data Set) assessment, dated 1/4/14, indicated Resident #13 had a BIMS (Brief Interview for Mental Status) score of 15 (fifteen) which indicated no cognitive impairment.</p> <p>A MAR, dated 3/1/14 - 3/31/14. indicated the portacath was to be flushed with 5 ml (milliliters) of heparinized saline daily when accessed. The MAR indicated the portacath had not been flushed on 3/24/14. 3/25/14, 3/26/14, and 3/27/14. The MAR lacked any documentation of the dressing being changed.</p> <p>During observation on 3/27/14 at 9:45 a.m., Resident #13 had a portacath with a transparent dressing, dated 3/12/14, on the left upper chest.</p> <p>During an interview on 3/27/14 at 9:30 a.m., LPN #1 indicated portacaths are to be flushed daily when accessed.</p> <p>During an interview on 3/27/14 at 9:55 a.m., the DoN (Director of Nursing) indicated an accessed portacath was to be assessed and the dressing changed weekly. The DoN</p>			

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	<p>indicated Resident #13 would be sent to the hospital to have the portacath accessed and flushed but the facility would provide the dressing change.</p> <p>A procedure, titled Dressing Change, Central Venous Catheter and dated 6/2012, indicated dressing changes were to be performed every 7 (seven) days and if the integrity of the dressing became compromised.</p> <p>3. The medical record of Resident #32 was reviewed on 3/27/14 at 1:51 p.m. The record indicated the diagnoses of Resident #32 included, but was not limited to, anxiety state, convulsions, alcohol induced dementia, hypothyroidism, esophageal reflux, hypertension, anemia, depressive disorder, lack of coordination, and fall with a fracture of the left arm.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 9/30/13 indicated the resident had received pain medications, received non-medication for pain, the resident had pain in the last 5 days, the resident had pain frequently in the last 5 days, and the resident verbalized moderate pain in the last 5 days.</p> <p>The most recent Quarterly MDS dated 2/13/14 indicated the resident had received PRN pain medications or was offered and declined, the resident had pain in the last 5 days, the resident had occasional pain or hurting over the last 5 days, and the resident had mild pain in the last 5 days. The BIMS (Brief Interview for Mental Status) was 7 out of 15 indicating moderate cognitive</p>			

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	<p>impairment.</p> <p>The medical record failed to reveal a care plan for pain.</p> <p>The MAR (Medication Administration Record) indicated the resident received Hydroco/Apap Tab (narcotic pain medication) 200 mg (milligrams) on 3/7/14 and on 3/27/14.</p> <p>The resident also received Ibuprofen Tab (anti-inflammatory pain medication) 400 mg on 3/4/14 and 3/8//14. The nurses notes failed to indicate assessments regarding the resident's pain prior to the pain medication administration. The nurses notes also failed to indicate the resident's response to the pain medication. There was no documentation for the reason or the effectiveness of the pain medication on the back of the MAR.</p> <p>In an interview with Resident #32 on 3/25/14 at 9:30 a.m., she indicated that she has pain without relief.</p> <p>In an interview with the DoN on 3/27/14 at 9:30 a.m., she indicated that she has had problems with the staff failing to document pain assessments.</p> <p>In an interview with the DoN (Director of Nursing) on 3/31/14 at 10:10 a.m., she indicated that she was unable to find a care plan for pain.</p> <p>A policy for Pain Assessment and Management provided by the DoN on 3/31/14 at 2:00 p.m. indicated, "...4) Document the results of the PRN (as needed) pain medication on the back of the MAR and contact the physician if needed."</p>			

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F000311 SS=D	<p>3.1- 37(a) 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for rehabilitation, in a sample of 15 who met the criteria, received recommended treatment and services after therapy ended, in that a care plan was not developed and range of motion and group exercises were not provided. (Resident #45)</p> <p>Finding includes:</p> <p>Resident #45's clinical record was reviewed on 3/26/14 at 9:49 a.m. The resident was admitted to the facility on 2/14/11 with diagnoses including, but not limited to, cerebrovascular disease, dementia, anxiety, depression, reflux, anemia, osteoarthritis, muscle weakness, osteoporosis, and hypertension.</p> <p>The resident was readmitted to the facility on 11/27/13 following a hospitalization. The initial 5-day Minimum Data Set (MDS) assessment, dated 12/4/13, indicated the resident required extensive assistance of two staff for transfers and ambulation. A 60-day MDS, dated 1/22/14, indicated the resident required extensive assistance of two staff for transfers and was non-ambulatory.</p> <p>Resident #45 received physical therapy from 11/27/13 to 2/5/14. The physical therapy</p>			F000311	<p>We are requesting a desk review. <u>F 311 Treatment services to improve maintain ADL's</u> The facility's intent is to comply with the federal requirement to assure residents are given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph A-1 in this section. A.</p> <p><b>ACTIONS TAKEN:</b> 1. Resident # 45 plan of care was reviewed with therapy and they're recommendations were implemented and resident was placed on restorative program.</p> <p>B. <b>OTHERS IDENTIFIED:</b> 1. A 100% audit was completed and no other residents were affected.</p> <p>C. <b>MEASURES TAKEN:</b> 1. Therapy and Restorative nurse was in serviced and a communication form will be completed for all residents referred to therapy with information being brought to the daily CQI meeting. 2. Referrals to Therapy will also be discussed weekly in the Medicare Meeting to include plan of care as appropriate. D. <b>HOW MONITORED:</b> 1. Administrator will review the</p>		

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	<p>discharge summary, dated 2/5/14, included the following discharge recommendations: "DC [discharge] PT [physical therapy] as progress has plateaued, continue CNA performing BLE [bilateral lower extremity] AAROM [active assisted range of motion] focusing on maintaining RLE [right lower extremity] hip and knee extension ROM [range of motion] and restorative group exercise class."</p> <p>There was no care plan for restorative or functional maintenance of range of motion or exercises according to the therapy recommendations.</p> <p>On 3/26/14 at 10:28 a.m., Resident #45 was observed being transferred from bed to a wheelchair by CNA #3 and LPN #1. She was then taken to the shower room and transferred by the same staff to the shower chair. CNA #3 completed the resident's shower, dressed the resident, and she and LPN #1 transferred the resident back to the wheelchair. She then dried her hair and finished up, taking the resident to the dining/activity area. No ROM exercises were observed. No group exercises were observed during the survey. The resident was observed to require moderate assistance of two staff for transfers.</p> <p>The MDS Coordinator was interviewed on 3/27/14 at 4:09 p.m. She indicated Resident #45 was not on a restorative program.</p> <p>The Director of Nursing indicated on 3/31/14 at 12:30 p.m. nursing must not have received any information about the therapy recommendations.</p> <p>The Rehabilitation and Restorative Nursing</p>		<p>results of the communications forms and completeness of referrals weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.</p>	

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F000318 SS=D	<p>policy and procedure, dated 6/1/12, was provided by the Director of Nurses on 3/31/14 at 2:00 p.m. The procedure included, but was not limited to, the following: "...Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy." "Restorative Nursing involves nursing interventions that assist or promote the resident's ability to attain his/her maximum functional potential...Rehabilitation or restorative care must meet all of the following additional criteria: 1. Measureable objectives and interventions must be documented in the care plan and in the clinical record..." "Therapist usually makes referral to MDS [Minimum Data Set] Coordinator for assessment of resident for Restorative Nursing Program..."</p> <p>3.1-38(a)(2)(B) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on record review, observation and interview, the facility failed to ensure range of motion exercises or an application of a splint were provided in 1 of 3 residents reviewed for contractures in a sample of 4 who met the criteria for contractures. (Resident #16)</p>	F000318	We are requesting a desk review. <u>F 318 Increase/Prevent in range of motion</u> . The facility's intent is to comply with the federal requirement to assure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and / or prevent further decline in range of	

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	<p>Findings include:</p> <p>During an observation on 3/24/14 at 11:35 a.m., Resident #16 was observed to be sitting in a wheelchair with a contracture of the right hand and fingers. No splint was in place. Resident #16 was observed again on 3/26/14 at 10:05 a.m. and 3/27/14 at 9:25 a.m. with no splint in place.</p> <p>During an observation on 3/27/14 at 11:11 a.m., CNA #1 and CNA #2 were observed to perform a.m. care to Resident #16. No range of motion exercises were provided during the care and the splint was not applied. Upon query, CNA #1 indicated she did not know where the splint was kept. The CNA further indicated the restorative aide provided the range of motion exercises and applied the splint to the resident's arm.</p> <p>The clinical record of Resident #16 was reviewed on 3/26/14 at 3:15 p.m. The clinical record indicated Resident #16 had diagnoses including, but not limited to, cerebral vascular disease and hemiplegia. The MDS (Minimum Data Set) assessment indicated Resident #16 had a BIMS (Brief Interview for Mental Status) score of 14, which indicated very slight cognitive impairment. The MDS indicated Resident #16 was not on a restorative program.</p> <p>A care plan, dated 2/25/14, indicated Resident #16 had a brace/splint to the right forearm to prevent further contractures. The care plan indicated the physician and family were to be notified of any changes, the resident was to be observed for any pain, increased contracture, skin impairment, range of motion was to be provided to the hand before the splint was placed, and the</p>		<p>motion. A. <b>ACTIONS TAKEN:</b></p> <p>1. Resident #16 restorative program and care plan was reviewed and program implemented. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit was completed and no other residents were identified. C. <b>MEASURES TAKEN:</b> 1. Orders will be reviewed daily in the CQI meeting for restorative care and splint orders. 2. Restorative nurse will review documentation of splints as related to the restorative program. 3. IDT Team will identify and observe residents with splint orders on daily rounds 3x weekly. D. <b>HOW MONITORED</b> 1. The administrator will review the results of the IDT rounds daily and CQI minutes weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring.</p>				

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	<p>splint was to be worn for 8 hours of each day.</p> <p>A care plan for a restorative program, dated 2/25/14, indicated the splint was to be applied from 9:00 a.m. and removed at 5 p.m. daily. The care plan further indicated a restorative program was provided for bed mobility and passive range of motion.</p> <p>During an interview on 3/24/14 at 11:19 a.m., Resident #16 indicated a splint was to be applied during the day to her right hand and range of motion exercises were to be performed but the facility does not provide anything to her right hand or fingers.</p> <p>During an interview on 3/26/14 at 9:55 a.m., the DoN (Director of Nursing) indicated Resident #16 wore her splint for 7-8 hours a day and the splint was applied at bedtime.</p> <p>During an interview on 3/27/14 at 11:55 a.m., CNA #1 indicated the restorative aide normally applied the splints/braces to the residents. CNA #1 indicated, at the present time, one of the restorative aides was on vacation and the other restorative aide had been required to work on a unit as a CNA. CNA #1 further indicated the CNA on the units attempt to do the restorative program but they are usually too busy.</p> <p>3.1-42(a)(1)</p> <p>her</p>				

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents sampled for weight loss, in the sample of 5 who met the criteria, was monitored closely and physician's orders obtained to attempt to maintain the resident's nutritional status. (Resident #60)</p> <p>Finding includes:</p> <p>On 3/26/14 at 9:35 a.m., LPN #1 was interviewed regarding Resident #60. The resident was observed, at that time, to be seated at a dining room table with an empty cup with some residual chocolate substance. LPN #1 indicated the resident had been given about 1/3 of a bottle of chocolate Ensure (nutritional supplement) with her morning medications. The LPN indicated the resident's daughter brought in the Ensure for the resident and they tried to get the resident to drink a bottle during each shift. She indicated the intake of the supplement was not documented anywhere.</p> <p>Resident #60's clinical record was reviewed on 3/26/14 at 9:37 a.m. The resident was</p>	F000325	<p>We are requesting a desk review. <u>F325 Maintain nutritional status unless unavoidable</u> It is the facilities intention that based on a resident comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible and receives a therapeutic diet when there is a nutritional problem. <b>A. Actions Taken</b> 1. Resident # 60 received an order for the nutritional supplements ensure that the family provides and amounts taken are documented on the MAR. Plan of care was updated with new order received. <b>B. Others Identified</b> 1. An audit was completed and no other resident were found to be affected. <b>C. Measures Taken</b> 1. Reeducation was completed for the IDT team related to weight management and program for</p>	04/23/2014

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	<p>admitted to the facility on 11/12/13 with diagnoses including, but not limited to, dementia with behavioral disturbances, hypertension, and depression.</p> <p>Physician's orders signed on 3/3/14 included orders for a general diet and orders for the resident's weight to be checked and recorded every 2 weeks, ordered on 12/3/13. There were no physician's orders for nutritional supplements.</p> <p>Review of the resident's weights included the following: 3/12/14 122.8 w/c (wheelchair) 3/10/14 121 2/24/14 127.4 2/14/14 125.2 1/10/14 130 w/c 12/15/13 137 11/12/13 137 standing (The resident had lost 10.36% of weight in 4 months.)</p> <p>Dietary Progress Notes, dated 1/22/14 at 1:50 p.m., indicated, "Resident was referred due to poor intake over approximately past 9 days, with 0-25% taken at meals. Res. receives the Regular Diet. Takes a daily MVI [multivitamin]. Weight recorded at 137 with new weight pending. Staff report no recent emesis, no use of diuretic, no apparent change in fluid status. RD [Registered Dietitian] suggests use of an appetite stimulant per MD orders. Will f/u on RD report."</p> <p>A dietary quarterly nutritional risk review, dated 3/13/14 at 2:29 p.m., indicated the following: Current weight 122.8, height 54, BMI 29.6 Weight change noted</p>		<p>monitoring. 2. Dietary Manager/IDT will review all weight concerns in the daily CQI meeting. 3. The Director of Nursing or Designee will review all new physician orders in the daily CQI meeting. <b>D. How monitored</b> 1. Weight program (SWAT) will be completed weekly to monitor all residents with weight concerns and appropriate interventions/care plans will be reviewed for those residents in the Weight Program 2. The administrator will review the results of the CQI and SWAT meeting minutes weekly. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.</p>				

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	<p>Intake meets 26-75% of estimated needs Regular diet Consumes 1000-1499 cc/day Relevant conditions and diagnoses: Alzheimer's, dementia Relevant nutrition related medications/supplements: shakes</p> <p>Summary of nutritional review: "Residents (sic) is on the crossings [Alzheimer's Unit], gets snakes (sic) 10-2-7 gets shakes, and cookies."</p> <p>The resident had a care plan, since 11/18/13, regarding being on "therapeutic diabetic precautions." Interventions included, but were not limited to, monitoring meal consumption, offer substitutions, and serve diet as ordered. The care plan was revised on 3/25/14 to include "actual weight loss since admit R/T [related to]: poor intakes dementia..." Interventions included the following: Diet as ordered Notify MD and Family as needed Obtain weight q month Offer substitutions if indicated RD as needed</p> <p>On 3/26/14 at 11:59 a.m., the resident was observed to receive her lunch tray from the Activity Assistant. She received a regular diet, with chocolate milk and tea. The resident would eat a bite or two, then hang her head down and say she wasn't hungry. Staff were observed to encourage the resident.</p> <p>The resident's weight loss, and the January, 2014 dietitian recommendation for an appetite supplement were reviewed with the Director of Nurses on 3/31/14 at 12:30 p.m.</p>			

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F000329 SS=D	<p>She indicated the physician had ordered a urinalysis when the dietary recommendation for an appetite supplement had been reported. She did not know why there were no physician's orders for supplements.</p> <p>The S.W.A.T. Program (Skin and Weight Assessment Team) policy and procedure was provided by the Director of Nurses on 3/31/14 at 2:00 p.m. Indications for implementing the policy included, but were not limited to, 5% or more weight change (undesirable) in 30 days, 10% or more weight change (undesirable) in 180 days. Documentation should include what interventions the resident is currently receiving and planned changes.</p> <p>3.1-46(a)(1) 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</p>			

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	<p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure blood pressure was monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident #70)</p> <p>Findings include:</p> <p>The medical record of Resident #70 was reviewed on 3/26/14 at 11:41 am. The record indicated the diagnoses of Resident #70 included, but was not limited to, cerebrovascular disease, anxiety disorder, major depressive disorder recurrent episodes, hypertension, chronic obstructive asthma, hyperlipidemia, and vascular dementia with depressed mood.</p> <p>The MAR indicated Resident #70 was receiving Metoprolol (antihypertensive medication) 25 mg (milligrams) bid (twice daily) which was started on 1/16/13.</p> <p>The medical record failed to have documentation of blood pressure monitoring since 11/12/13.</p> <p>An interview with LPN #2 on 3/26/14 at 4:12 p.m., indicated she could not find any other blood pressures documented at this time.</p> <p>3.1-48(a)(3)</p>	F000329	<p>We are requesting a desk review. <u>F329D Drug Regimen is free from unnecessary drugs</u> . The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that prohibit a medication regimen that is free from unnecessary medications or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. A. <b>ACTIONS TAKEN:</b> 1. Resident #70 medication order was clarified with the MD. Resident # 70 Blood Pressure will be taken BID and documented on MAR. B. <b>OTHERS IDENTIFIED:</b> 1. A 100% audit was completed and no other residents were affected. C. <b>MEASURES TAKEN:</b> 1. Licensed Nursing staff was in serviced on BP monitoring and following MD orders. D. <b>HOW MONITORED:</b> 1. DON/Designee will monitor/audit MARS 2 times weekly for four weeks to ensure Blood Pressure Documentation is accurate. Then at least weekly thereafter. 2. The Administrator will review the audit results weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of</p>	04/23/2014			

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F000332 SS=E	<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 3 of 6 residents observed during medication administration, in that 6 errors were made out of 33 opportunities for error, resulting in an error rate of 18.18 percent. Two (2) of 4 licensed nurses observed made errors. (Residents #48, #57, #6) (RN #1, LPN #2)</p> <p>Findings include:</p> <p>1. During an observation on 3/26/14 at 9:56 a.m., RN #1 was observed to be administering medications to Resident #48. RN #1 indicated Resident #48 needed to have 2 (two) insulin injections. RN #1 indicated Resident #48 was to receive Lantus insulin 36 units subcutaneous per Flexpen.</p> <p>During an observation on 3/26/14 at 10:11 a.m., RN #1 was observed to be administering medications to Resident #48. RN #1 indicated Resident #48 needed to receive her routine Novolog insulin 24 units subcutaneous and Novolog insulin 5 units subcutaneous per Flexpen to cover a morning blood sugar result of 363. RN #1 indicated Resident #48 was out of the Novolog insulin per Flexpen and RN #1 proceeded to borrow the Novolog insulin 100 units/milliliter from Resident #38.</p>	F000332	<p>ongoing monitoring.</p> <p>We are requesting a desk review. <u>F332 Free of Medication Error Rates of 5% or more</u> . The facility's intent is to ensure it is free of medication error rates of five percent or greater. <b>A. ACTIONS TAKEN:</b> 1. Resident 48, 57. 6 medication errors were completed. 2. RN #1 and LPN #2 have been in serviced on the facility policy and procedure on medication pass. <b>B. OTHERS IDENTIFIED:</b> 1. 100% audit was completed at the time of occurrence. No others affected. <b>C. MEASURES TAKEN:</b> 1. Nursing staff was in serviced on Medication pass policy and procedures. 2. RN#1 and LPN #2 had a med pass competency completed. <b>D. HOW MONITORED:</b> 1. DON/Designee will monitor/audit MED pass 3 times a week for 4 weeks. Any negative findings will be immediately addressed. Then random monitoring thereafter at least time a week. 2. The Administrator will review the audit results weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA</p>		

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	<p>The clinical record was reviewed on 3/26/14 at 11:00 a.m., a physician's order, dated 3/5/14, indicated Resident #48 was to receive Lantus insulin 36 units subcutaneous per Flexpen prior to breakfast.</p> <p>A physician's order, dated 3/5/14, indicated Resident #48 was to receive the Novolog insulin prior to breakfast.</p> <p>Upon query, RN #1 indicated the blood sugar was obtained by the night shift probably "around 6 or 6:30 a.m. this morning." RN #1 indicated Resident #48 had eaten breakfast and then was given a shower and she was unable to administer the insulin until that time. RN #1 indicated Resident #48 had been out of the Novolog insulin and it had been ordered 2 (two) days ago.</p> <p>During an interview on 3/26/14 at 11:20 a.m., LPN #2 indicated if a resident had insulin ordered for a specific time, the insulin should be given at that time. LPN #2 indicated she would have administered the insulin prior to Resident #48 having breakfast.</p> <p>2. During an observation on 3/26/14 at 9:16 a.m., RN #1 was observed to administer Bion Ophthalmic 1 (one) drop to each eye of Resident #57.</p> <p>A physician's order, dated 12/17/14, indicated Bion eye drops were to be administered into the left eye only..</p> <p>During an observation on 3/26/14 at 9:16 a.m., RN #1 was observed to obtain a B/P (blood pressure) on Resident #57. The B/P was 98/54 for Resident #57. RN #1 was observed to administer Metoprolol 25 mg 1/2</p>		Meeting for determination of ongoing monitoring.	

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F000353 SS=E	<p>tablet orally in pudding to Resident #57.</p> <p>A physician's order, dated 8/26/11, indicated Metoprolol was not to be given for a systolic B/P less than 100.</p> <p>3. LPN #2 was observed to administer medications to Resident #6 on 3/27/14 at 8:40 a.m. The LPN administered 10 and 1/2 tablets orally with water and 2 chewable tablets. She then administered an inhaled medication and a respiratory treatment.</p> <p>Resident #6's clinical record was reviewed on 3/27/14 at 8:58 a.m. The resident had physician's orders, signed 3/3/14, including, but not limited to, the following medications: Furosemide 20 milligrams take one tablet by mouth every morning, scheduled for 8:00 a.m. Systane gel drops, instill one drop in each eye every 12 hours, scheduled for 8:00 a.m.</p> <p>LPN #2 was interviewed at 9:14 a.m. on 3/27/14. She checked the medication record and then checked the medications in the drawer. She indicated the furosemide was not in the drawer so she would have to get it out of the emergency drug kit, that she had missed it earlier. She indicated she had forgotten to give the eye drops.</p> <p>3.1-48(c)(1) 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined</p>			

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	<p>by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to ensure sufficient nursing staff to meet the needs of the residents for 6 of 20 residents interviewed, for 2 of 6 months' resident council minutes reviewed, and for 1 of 2 observations of morning snacks being passed. Residents complained of not having enough staff, resident council minutes indicated complaints about staffing, and morning snacks were observed to go unpassed. (Residents #123, #126, #129, #130, #131, #132, Resident Council Minutes 1/28/14, 10/9/13)</p> <p>Findings include:</p> <p>During Stage 1 interviews on 3/24/14 and 3/25/14, Residents #123, #126, #129, #130, #131, and #132 confidentially indicated difficulty getting call lights answered and problems with not having enough staff.</p>	F000353	<p>We are requesting a desk review. <u>F 353 Sufficient 24-hour nursing staff per care plans</u> . The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. A. <b>ACTIONS TAKEN:</b></p> <p>1. Review of resident care needs and placement of nursing staff was implemented to ensure resident care needs are met and call lights are answered timely.</p> <p>B. <b>OTHERS IDENTIFIED:</b> 1. All residents have the potential to be affected. No residents were determined to be negatively</p>	04/23/2014			

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F000431 SS=E	<p>Resident Council minutes were reviewed on 3/26/14 at 1:26 p.m. Minutes from 1/28/14 indicated residents stated there was not enough help, that nurses didn't help answer call lights, that CNAs turned off lights and said they'd be right back. Resident Council minutes dated 10/9/13 indicated a complaint about call lights taking 30 minutes to get answered.</p> <p>During an observation on 3/27/14 at 11:00 a.m., the morning snacks were observed in a container with ice in it, sitting on a cart in the East Back Unit.</p> <p>During an interview on 3/27/14 at 11:54 a.m., CNA #1 indicated the morning snacks had not been passed to the residents. CNA #1 indicated lunch trays had arrived to the unit and the trays would be passed at that time. CNA #1 indicated normally the RA (Resident Aide) should pass the snacks but she was usually still passing ice when the snacks were delivered. CNA #1 further indicated the nurses would help with passing snacks when they were able but everyone had been busy.</p> <p>3.1-17(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the</p>		<p>affected. C. <b>MEASURES TAKEN:</b> 1. Nursing staff in serviced on hydration and passing of snacks. 2. The Director of Nursing or designee review resident care needs and place staff per needs of residents. The placement of staff and scheduling is reviewed with the staff member who handles nursing scheduling as needed and at a minimum one time weekly. 3. A Guardian Angel program is implemented to ensure resident concerns or needs is being addressed. The Guardian Angel Program is reviewed weekly in the morning meeting. D. <b>HOW MONITORED:</b> 1. Administrator will monitor daily staffing hours from HR report. 2. DON/Designee will monitor compliance with passing of snacks at 10am and 2pm. 3. Social Service will complete 2 resident interviews per week for 4 weeks till no negative findings then randomly thereafter. The Administrator will review the results of the interviews weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of any ongoing monitoring</p>				

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	<p>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 medications were labeled with open dates, discarded according to policy, and stored in clean areas, for 2 of 3 medication storage areas observed. (Alzheimer's Unit, 200 Unit) This affected 5 residents' with medications</p>	F000431	<u>F 431 Drug records, labels/store drugs and biological</u> . The facility's intent is to comply with the federal requirement to develop and implement written policies and procedures that employs and obtains the services of a licensed pharmacist who establishes a system of records	04/23/2014

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	<p>stored. (Residents #36, #22, #2, #78, #133)</p> <p>Findings include:</p> <p>1. On 3/31/14 at 9:00 a.m., LPN #2 was working on the Alzheimer's Unit. She indicated insulins were kept for 28 days after opening and eye drops were kept for 3 months after opening.</p> <p>The medication cart for the unit was observed at that time. The following medications were observed: Resident #36 had Patanol (allergy eye drops) and Gentamycin (antibiotic eye drops) that had been opened, but not dated. Resident #22 had Liquitears (lubricant eye drops) with an open date of 11/17/13, and Robitussin (cough syrup) with a discard date of 2/4/14. LPN #2 indicated they were to discard medications by the discard date. A box of Refresh (lubricant eye drops) was in the cart with no identification label or instructions and no open date. A medication cup was observed with unidentified pills in it in a drawer. There was no name or identifying information on the cup.</p> <p>2. The 200 hall medication room and cart were observed on 3/31/14 at 9:10 a.m. The following observations were made: Resident #2 had a bottle of Liquitears (lubricant eye drops) with an open date of 12/26/13. Resident #78 had a bottle of Liquitears with an open date of 11/17/13. Resident #133 had two mixed bags of intravenous Cefazolin (antibiotic) solution with a discard date of 3/21/14. According to LPN #3, the resident was gone from facility</p>		<p>of receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation. A. <b>ACTIONS TAKEN:</b> 1. Residents 36, 22, 2, 78, 133 medications were either replaced or discarded per policy and procedure. 2. Alzheimer's Unit and 200 hall medication room/carts were cleaned. B. <b>OTHERS IDENTIFIED:</b> 1. 100% audit was completed on all carts and med rooms and any issues were immediately addressed. C. <b>MEASURES TAKEN:</b> 1. Nurses in serviced on expiration dates, date open of medications, cleanliness of med rooms and monitoring for labeling of resident juices and medications. 2. DON designee will check carts and med rooms weekly and results will be followed up in CQI meeting. 3. Night nursing staff will clean medication carts/medication rooms nightly. D. <b>HOW MONITORED:</b> 1. The DON/Designee will observe a medication cart and med room two (2) times a week for four (4) weeks then weekly for two (2) weeks, then monthly thereafter for cleanliness and date opened on applicable medications. 2. The administrator will review the results weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the</p>				

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F000441 SS=D	<p>and the medication should have been discarded.</p> <p>The interior of the refrigerator was soiled with a dried yellow substance. Orange juice was in a plastic jug, unlabelled, with no date. LPN #3 indicated it was used for low blood sugars and should have had a date.</p> <p>The countertop was soiled with a brown substance. There was dust and debris on the floor.</p> <p>The policy and procedure for Medication Storage in the Facility, dated 6/19/12, was provided by the Director of Nurses on 3/31/14 at 2:00 p.m. The policy and procedure included, but was not limited to, the following: "...Medications and biologicals area stored safety (sic), and properly following the manufacture or supplier recommendations..." "...Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from pharmacy if a current order exists." "...Medication storage areas are kept clean, well lit, and free of clutter..."</p> <p>3.1-25(o) 3.1-25(k) 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>		monthly and quarterly QA Meeting for determination of ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/01/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF PRINCETON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper handwashing was performed in 2 of 4 residents observed receiving care and/or injections. (Resident #48, Resident #16)</p> <p>Findings include:</p> <p>1. During an observation on 3/26/14 at 9:56</p>	F000441	<p>We are requesting a desk review. <u>F 441 Infection control</u> - The facility's intent is to comply with the federal requirement to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. <b>ACTIONS TAKEN:</b> 1. RN #1 and CNA's #1 and #2 were in services and observed 1:1 by nursing on hand</p>	04/23/2014

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	<p>a.m. and 10:11 a.m., RN #1 was observed to administer Lantus insulin to the right lower abdominal quadrant of Resident #48 without applying gloves.</p> <p>During and observation on 3/26/14 at 10:11 a.m., RN #1 was observed to administer Novolog insulin to the left middle quadrant of the abdomen of Resident #48 without applying gloves.</p> <p>A policy, dated 2/6/14, indicated gloves were to be applied prior to the administration of a subcutaneous injection.</p> <p>2. During an observation on 3/27/14 at 11:11 a.m., Resident #16 was observed to be receiving a partial bed bath. Resident #16 had been incontinent of stool.</p> <p>CNA #1 and CNA #2 was observed to wash their hands prior to applying gloves. During the partial bath, CNA #1 and CNA #2 changed gloves with no evidence of handwashing.</p> <p>During an interview on 3/31/14 at 8:35 a.m., CNA #4 indicated hands should be washed and gloves applied at the beginning of the bath, and gloves should be removed and hands should be washed after performing pericare, and at the end of the bath.</p> <p>A policy, dated 7/1/11, indicated hands should be washed immediately after gloves are removed. The policy further indicated it may be necessary to wash hands between tasks and procedures on the same patient.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>		<p>washing/glove use for compliance. B. <b>OTHERS IDENTIFIED:</b> 1. A complete (100%) audit was done and no other residents were affected. C. <b>MEASURES TAKEN:</b> 1. All licensed staff has been in serviced on Hand Hygiene/Glove procedure prior to their next worked shift. D. <b>HOW MONITORED:</b> 1. DON/Designee will observe 3 staff members for proper hand washing/glove use for 2 weeks and then 1 staff member weekly. 2. Results of the hand washing will be reviewed in the daily CQI meeting. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.</p>	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>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 9 of 31 resident rooms observed, in that closet doors were missing, cove base was loose, and walls and furniture were marred and chipped. (Rooms #124, 229, 217, 123, 223, 125, 230, 224, 226)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Room 124 was observed on 3/24/14 at 10:54 a.m. The cove base was loose in a corner of the bathroom. It was the same on 3/31/14 at 9:07 a.m.</li> <li>Room 229 was observed on 3/25/14 at 11:18 a.m. The bathroom wall had a 6 inch section of peeled paint, and the walls were marred. It was the same on 3/31/14 at 9:19 a.m.</li> <li>Room 217 was observed on 3/24/14 at 10:53 a.m. The built-in chest in the room had marred drawers. Wood was chipped off the bathroom door frame and paint was chipped off the wall in the bathroom. The observation was the same when observed on 3/31/14 at 9:22 a.m.</li> <li>Room 123 was observed on 3/24/14 at 11:16 a.m. and 3/31/14 at 9:11 a.m. The closet had no door.</li> </ol>	F000465	<p>We are requesting a desk review. <u>F 465 Sage /Functional /Sanitary/comfortable environment</u> It is the facilities intention to follow federal regulations and provide a safe functional sanitary and comfortable environment for the resident, staff and the public.</p> <p><b>A.Actions:</b> 1. All identified environmental concerns have been addressed. B. Others Identified 1. 100 % audit completed. No residents affected. C. Measures taken: 1. During walking rounds any environmental concerns will be identified. These rounds will be completed at least 3x weekly. 2. Maintenance Director will review repair requests on a daily basis and will prioritize repairs based on urgency and safety needs. Any major repairs will be reviewed with the Administrator and a plan of action will be implemented. 3. The Maintenance Director will continue monitor facility repairs and will follow the Preventative Maintenance Program. D. How monitored 1. The Administrator during the CQI meeting will review the results of the walking rounds daily and maintenance rounds weekly. Any inconsistent results will be immediately</p>	04/23/2014			

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	<p>5. Room 223 was observed on 3/25/14 at 10:01 a.m. Wood was chipped off the chair rail at the top of bed B. The wall above the bed was chipped and paint missing. The bathroom wall was marred with missing paint. It was the same on 3/31/14 at 9:25 a.m.</p> <p>6. Room 125 was observed on 3/25/14 at 3:42 p.m. and 3/31/14 at 9:11 a.m. The closet had no door.</p> <p>7. Room 230 was observed on 3/25/14 at 10:30 a.m. The cover to the heating/cooling unit was broken off. The bathroom wall was marred and chipped. It was the same on 3/31/14 at 9:29 a.m. The carpet in the bedroom was soiled and stained.</p> <p>8. Room 224 was observed on 3/24/14 at 12:02 p.m. The chest of drawers had wood chipped off, paint chipped off the wall in the bathroom, and soiled grout in the toilet on the bathroom floor. It was the same on 3/31/14 at 9:32 a.m.</p> <p>9. Room 226 was observed on 3/25/14 at 9:21 a.m. The wood was chipped off of the cabinets and the bathroom door. The toilet back did not fit the tank and the area around the toilet base was soiled.</p> <p>10. The Administrator was interviewed on 3/31/14 at 12:30 p.m. She indicated she had noticed the closet doors missing and would make sure the other areas were corrected.</p> <p>3.1-19(f)</p>		clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring.				