

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2012
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NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 14, 15, 16, 17, 18, 21, and 22, 2012.</p> <p>Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240</p> <p>Survey Team: Karen Lewis, RN- TC Ginger McNamee, RN Betty Retherford, RN</p> <p>Census Bed Type: SNF/NF: 128 Residential: 8 Total: 136</p> <p>Census Payor Type: Medicare: 13 Medicaid: 94 Other: 29 Total: 136</p> <p>Residential sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 30,</p>	F0000	F 000This Plan of Correction is preparedand executed because it is requiredby the provisions of State and Federallaws and regulations and not becauseWesleyan Health Care Center agreeswith the allegations and citations listed.Wesleyan Health Care Center maintainsthat the alleged deficiencies do notindividually or collectively jeopardizethe health and safety of the residents,nor are they of such a character so as tolimit our capabilities to render adequatecare.	

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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	2012 by Bev Faulkner, RN				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure medically-related social services were provided in regards to identification of behaviors requiring the need for antipsychotic medication and the need for behavior monitoring for 1 of 10 residents reviewed for unnecessary medications. (Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 5/16/12 at 3:45 p.m.</p> <p>Diagnoses for Resident #19 included, but were not limited to mental retardation and episodic mood disorders.</p> <p>A health care plan problem, dated 5/16/12, indicated "Use of drugs having an altering effect on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems AEB [as evidenced by] decline mood/behavior,</p>	F0250	<p>F250: Corrective Actions Taken for those residents affected by the alleged deficient practice: Care plan implemented with specific behaviors to observe for on resident #19 as well as behavior monitoring implemented. Identification of and corrective actions taken for other residents having the potential to be affected by alleged deficient practice: All residents receiving antipsychotic medications have the potential to be affected by alleged deficient practice. Clinical record of all residents receiving antipsychotic medications have been reviewed and corrected if necessary to include behaviors to observe for and behavior monitoring on or before 6/8/2012. Measures taken and Systemic changes made to ensure the alleged deficient practice does not recur: Clinical records of all residents receiving antipsychotic medications have been reviewed and updated. Newly admitted residents as well as new orders for antipsychotic medications are reviewed every business day in order to identify specific behaviors for medication use with behavior monitoring implemented as necessary. Staff have been inserviced on behavior management on or before 6/8/2012. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be</p>	06/11/2012	

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	<p>decline cognitive status." One of the approaches for this problem was "Observe resident mood state and behavior."</p> <p>The May 2012 recapitulation of physician's orders, indicated Resident #19 received Risperidone (an antipsychotic medication) 0.5 milligrams twice daily for episodic mood disorders. The original date of this order was 3/20/12.</p> <p>The clinical record lacked any information related to the specific behaviors for which the medication was being given. The clinical record lacked any behavior monitoring information for Resident #19.</p> <p>During an interview on 5/22/12 at 10:40 a.m., the Social Services Director indicated she had not identified the specific behaviors for which the antipsychotic medication was being given and no behavior monitoring was being done.</p> <p>The 4/11/11, updated "Point Click Care Procedure for Behavior Documentation" policy was provided by the Director of Nursing at 10:15 a.m. on 5/22/12. The policy indicated CNA's were to document behaviors in POC [Point of Care] of Point Click</p>		<p>completed by Social Services every business day of physician orders for newly ordered antipsychotic medications for new and current residents with implementation of behavior monitoring as well as behaviors to observe for. Audit will be completed every business day and will be ongoing. The results will be forwarded to the quarterly QA meetings for review and any concerns addressed. Completion Date: 6/11/2012</p>				

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	<p>Care when behaviors occur. The CNA would notify the nurse of the behavior as well. Social Services was to follow-up documentation of behaviors under progress notes utilizing the Behavior Note. The policy indicated behaviors should be documented in some form by all staff witnessing a behavior. Residents that have a new behavior will have the task schedule changed for as needed to every shift for two weeks to determine if the behavior is ongoing. This will allow for appropriate assessment of the behavior. Social Services was to check the dashboard for any behavior alerts daily except weekends and holidays. Social Services was to review the progress notes for any behavior documentation daily except weekends and holidays.</p> <p>3.1-34(a)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed related to resident behaviors requiring the need for psychotropic medication use for 1 of 10 residents reviewed for unnecessary medications (Resident #19) and failed to ensure a comprehensive plan of care was developed related to the need for oral care for 1 of 3 residents reviewed of the 4 who met the criteria for oral health status. (Resident #101)</p>	F0279	<p>F279: Corrective Actions Taken for those residents affected by the alleged deficient practice: Care plan for resident #19 has been updated to reflect behavior monitoring and interventions necessary for antipsychotic medication use. Care plan for resident #101 has been updated to reflect oral/dental needs. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All resident have the potential to be affected by alleged deficient practice. Care plans have been reviewed for all residents taking antipsychotic medications and have been corrected if indicated.</p>	06/11/2012

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	<p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 5/16/12 at 3:45 p.m.</p> <p>Diagnoses for Resident #19 included, but were not limited to, mental retardation and episodic mood disorders.</p> <p>The May 2012 recapitulation of physician's orders, indicated Resident #19 received Risperidone (an antipsychotic medication) 0.5 milligrams twice daily for episodic mood disorders. The original date of this order was 3/20/12.</p> <p>A health care plan problem, dated 5/16/12, indicated "Use of drugs having an altering effect on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems AEB [as evidenced by] decline mood/behavior, decline cognitive status." One of the approaches for this problem was "Observe resident mood state and behavior."</p> <p>The comprehensive plan of care for Resident #19 lacked any description of the specific behaviors for which the medication was being given, the need</p>		<p>Care plans have been reviewed for all residents related to oral care and corrected if indicated on or before 6/8/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Care plans reviewed and amended when necessary for oral care and antipsychotic medications. Staff responsible for care plan development and revision have been inserviced on care plans on or before 6/8/2012. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur:</p> <p>A Quality Assurance audit will be completed by the DON/designee to review care plans for oral/dental needs as well as antipsychotic medication use on three residents per unit three times per week for three months then monthly for three months and then quarterly there after. The results of the audit will be forwarded to the QA quarterly meetings for review and any concerns addressed. Completion Date: 6/11/2012</p>		

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	<p>for behavior monitoring, and lacked any interventions developed to help reduce the need for the antipsychotic medication.</p> <p>During an interview on 5/22/12 at 10:40 a.m., the Social Services Director indicated she had not identified the specific behaviors for which the antipsychotic medication was being given, no behavior monitoring was being done, and no interventions had been developed to help reduce the need for the medication.</p> <p>2.) The clinical record for Resident #101 was reviewed on 5/16/12 at 10:16 a.m.</p> <p>Diagnoses for Resident #101 included, but were not limited to, dementia, hypothyroidism, and osteoporosis.</p> <p>A nursing admission observation note, dated 6/9/11, indicated Resident #101 required assistance with oral care.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 3/1/12, indicated Resident #101 was cognitively impaired. The assessment indicated she required extensive assistance from one staff member for personal</p>			

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	<p>hygiene needs.</p> <p>During a family interview on 5/15/12 at 4:00 p.m., Resident #101's family member indicated the resident was not receiving the assistance she needs with brushing her teeth. The family member indicated resident had been seen by the dentist and the dentist indicated resident was not receiving satisfactory oral care.</p> <p>Progress notes from the dentist, dated 10/20/11 and 5/15/12, indicated resident's teeth needed to be brushed at least two times a day.</p> <p>The comprehensive health care plan for Resident #101 lacked any information related to oral/dental care, or assistance with personal hygiene.</p> <p>During an interview with the Director of Nursing on 5/21/12 at 10:15 a.m., any health care plans in place prior to 5/16/12 related to oral/dental care, and assistance with personal hygiene were requested.</p> <p>The facility failed to provide any additional information as of exit on 5/22/12.</p> <p>3.1-35(a)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a resident was given a dental rinse as ordered by the physician for 1 of 3 residents reviewed of the 4 who met the criteria for oral health status (Resident #19) and failed to ensure comprehensive fluid intake was monitored for 2 of 3 residents reviewed with orders for fluid restrictions. (Resident #19 and #121)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 5/16/12 at 3:45 p.m.</p> <p>Diagnoses for Resident #19 included, but were not limited to, hypertension, generalized muscle weakness, dysphagia oropharyngeal phase, congestive heart failure, diabetes mellitus, mental retardation, syndrome of inappropriate anitdiuretic hormone secretion</p>	F0309	<p>F309:Corrective Actions Taken for thoseresidents affected by allegeddeficient practice:The facility is unable to correct the alleged deficient practice related to the lack of Peridex mouth rinse administration for resident #19. The physician and family have been notifiedand an oral assessment has been completed on resident #19. Identification of and corrective actions taken for other residentshaving the potential to be affectedby the alleged deficient practice:All residents receiving physician orderedmouth rinse have the potential to be affected by the alleged deficient practice. An audit of all residents receiving physician ordered mouth rinse has been conducted to ensureno other resident has been affected by the alleged deficient practice. Nursingstaff inserviced on medicationadministration on or before 6/8/2012.Measures taken and systemicchanges made to ensure the alleged deficient practice does notrecur:Physician ordered mouth rinse ordershave been reviewed to ensure proper</p>	06/11/2012	

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	<p>(SIADH), and history of water toxicity.</p> <p>a.) The admission nursing assessment, dated 11/1/11, indicated the resident had his own teeth and some were missing, broken, or carious. The assessment indicated he needed assistance with oral care.</p> <p>A dental progress note, dated 5/21/12 and faxed to the facility from the dental office on 5/21/12, indicated Resident #19 had been seen in the dental office on 11/16/11. The note indicated they found "a lot of tarter and some gum disease. ...We recommend him to use peridex rinse daily and good home care daily."</p> <p>The current May 2012 physician's orders, indicated the resident had an order for Peridex (chlorhexidine gluconate) mouth rinse 0.12%, "Use 15 milliliters (ml) in mouth, rinse two times daily." The original date of this order was 11/16/11. This indicated a total of 30 ml would be used each day.</p> <p>A health care plan problem, dated as initiated on 5/16/12, indicated Resident #19 needed assistance with activities of daily living related to impaired cognitive functioning. One of the approaches for this problem</p>		<p>administration. Staff inservedon medication administration on or before 6/8/2012.How the corrective actions will bemonitored and the QA system implemented to ensure the alleged deficient practice does notrecur:A quality assurance audit will be completed by the DON/designeeof medication pass for compliancethree times per week per unit for three months and then monthly there after.The results of the audit will be forwardedto the QA quarterly meetings for reviewand any concerns addressed.Completion Date: 6/11/2012</p> <p>F309: Corrective actions taken for those residents affected by the alleged deficient practice: Unable to correct the alleged deficient practice for resident #19. Physician and family notified and cna assignment Kardex has been updated related to fluid restriction. Physician has revised docusate sodium order. Fluid restriction for resident #121 has been discontinued. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents on physician ordered fluid restriction have the potential to be affected by alleged deficient practice. A review of all residents on a fluid restriction has been completed with care plans as well as cna assignment Kardex updated if necessary on or before 6/8/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:</p>		

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	<p>was "[name of resident] requires extensive staff participation with personal hygiene and oral care. Give chlorhexidine per MD [medical doctor] orders for antimicrobial oral care."</p> <p>During an observation with QMA #1 on 5/18/12 at 10:15 a.m., Resident #19 had 3 bottles of the Peridex rinse, all dated as delivered on 1/22/12, in supply in the medication cart which contained the following amounts:</p> <p>Each bottle was a 16 ounce bottle which held approximately 480 ml when full.</p> <p>One bottle was full (480 ml) One bottle was 1/2 full (240 ml) One bottle was 3/4 full (360 ml)</p> <p>This indicated a total of 1080 ml of the Peridex rinse was still in supply that had been delivered on 1/22/12.</p> <p>The clinical record lacked any documentation of the resident refusing the mouth rinse. Documentation indicated the resident received the medication twice daily (30 ml total) from 11/17/11 thru 5/17/12. This would be a total of 182 days. This indicated the facility should have administered 5,460 ml of the mouth rinse during this time</p>		<p>Audit completed on all residents on a fluid restriction with updates made to care plans as well as cna assignment Kardex if necessary. Staff inserviced on fluid restriction expectations, cna assignment Kardex, care plan revisions, as well as physician notification on or before 6/8/2012.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be completed by the DON/designee on all residents with physician ordered fluid restriction for compliance and physician notification as needed three times per week for three months, monthly for three months and then quarterly thereafter. The results of the audit will be forwarded to the QA meetings quarterly for review and any concerns addressed. Completion Date: 6/11/2012</p>				

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	<p>period. (182 days multiplied by 30 ml a day).</p> <p>During an interview with the Pharmacy Manager on 5/18/12 at 11:45 a.m., she indicated a maximum of six of the 16 ounce bottles of Peridex mouth rinse had been sent to the facility since the order originated on 11/16/11. This indicated the total amount of mouth rinse sent to the facility was 2,880 ml. Approximately 1,080 ml of the mouth rinse was still in supply in the medication cart. This indicated only 1,800 ml of the mouth rinse had been given when 5,460 ml should have been used.</p> <p>During an interview with the Director of Nursing (DoN) and LPN #2 (the Unit Manager for Resident #19's hall) on 5/18/12 at 1:39 p.m., additional information was requested related to the large amount of the mouth rinse left in supply and not enough having been sent from the pharmacy to cover the total amount required during the time period noted above.</p> <p>During an interview on 5/21/12 at 4:30 p.m., the DoN indicated she had talked to the dentist who had ordered the medication on 11/16/11 and no samples of the rinse had been sent for use. She indicated she had no</p>						

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	<p>information to provide related to the discrepancy between the amount of rinse that should have been used and the amount of rinse that had actually been used from the supply sent from the pharmacy.</p> <p>b.) The clinical record for Resident #19 indicated he had a fluid restriction of 1000 ml daily.</p> <p>A health care plan problem, revised on 3/1/12, indicated the resident had a 1000 ml fluid restriction. Approaches for this problem included, but were not limited to, "monitor food and fluid intakes" and "dietary to provide 800 cc (cubic centimeter which is equal to a ml) nursing 200 cc fluid."</p> <p>A health care plan problem, revised on 1/9/12, indicated "Problematic manner in which resident acts characterized by inappropriate behavior; [name of resident] is on a fluid restricted diet but has been noted to drink water from his faucet in his room." One of the approaches for this problem was to "monitor [name of resident] closely and report to nursing supervisor." The health care plan lacked any information as to when the physician should be notified of the resident intake amounts in excess of</p>						

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	<p>1000 ml per day.</p> <p>During a review of the tray diet slips for breakfast, lunch, and supper for Resident #19, provided by the Dietary Manager on 5/21/12 at 3:25 p.m., they indicated the resident was to receive 6 ounces of total fluids for breakfast, 4 ounces of fluid with lunch, and 4 ounces of fluid at supper for at total of 14 ounces. This indicated dietary would be providing 420 ml of fluids instead of the 800 ml noted on the resident's health care plan. (one ounce equals 30 ml)</p> <p>During an interview on 5/21/12 at 3:25 p.m., the Dietary Manager indicated the dietary staff only put the above amounts of fluids on the resident's tray. She indicated he frequently asked for additional fluid items and the CNAs would ask dietary for them.</p> <p>The May 2012 medication administration record indicated Resident #19 received routine medications only twice daily. One of the medications given in the morning med pass was docusate sodium (a stool softener) 200 milligrams. The order indicated the resident was to receive this medication with a full glass of water. (240 ml) The original</p>			

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	<p>date of this order was 11/1/11. This indicated the nursing staff would have to give more that 200 ml of fluids daily which is in excess of the amount noted on the resident's health care plan.</p> <p>The May 2012 Medication Administration Record (MAR) for Resident #19 indicated the resident consumed the following amount of fluids on each of the dates noted below:</p> <p>May 1 = 730 ml total May 2 = 730 ml total May 3 = 730 ml total May 4 = 730 ml total May 5 = 720 ml total May 6 = 720 ml total May 7 = 720 ml total May 8 = 880 ml total May 9 = 720 ml total May 10 = 880 ml total May 11 = 840 ml total May 12 = 900 ml total May 13 = 360 ml for evening med pass (a.m. med pass area is blank) May 14 = 940 ml total May 15 = 1080 ml total May 16 = 1020 ml total</p> <p>During a review of an intake report for Resident #19, generated from entries recorded by the CNAs into the touch</p>				

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	<p>screen documentation device, provided by the DoN on 5/17/12, the following daily intake amounts were recorded:</p> <p>May 1 = 2,760 ml May 2 = 1,680 ml May 3 = 2,280 ml May 4 = 2,280 ml May 5 = 2,280 ml May 6 = 2,040 ml May 7 = 1,680 ml May 8 = 2,040 ml May 9 = 1,800 ml May 10 = 1,780 ml May 11 = 1,680 ml May 12 = 1,980 ml May 13= 2,250 ml May 14 = 2,320 ml May 15 = 1,920 ml May 16 = 1,800 ml</p> <p>The CNA assignment sheet for Resident #19, dated 5/17/12, lacked any information related to the resident having a fluid restriction.</p> <p>During an interview with the Director of Nursing (DoN) and LPN #2 (the Unit Manager for Resident #19's hall) on 5/18/12 at 1:39 p.m., additional information was requested related to the intakes in excess of 1000 ml documented above, when the total daily intakes were reviewed, the lack</p>			

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	<p>of fluid restriction information noted on the CNA assignment sheet, and the lack of interventions in place to help lessen the resident's non-compliance with the fluid restriction.</p> <p>During an interview on 5/18/12 at 1:39 p.m., the DoN indicated the nursing staff would have to generate a computer report to determine the total number of milliliters of fluid consumed by the resident each day. She indicated the nursing staff frequently reminded the resident that he was not supposed to drink fluids other than those provided to him. No additional information related to the above information requests was provided.</p> <p>2.) Resident #121's clinical record was reviewed on 5/21/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, hypertension, senile dementia with delusional features, and hyposmolarity and/or hypernatremia.</p> <p>The resident had a signed 4/23/12, physician's order for a daily 1500 ml [milliliter] fluid restriction. The order was initiated on 4/25/12.</p> <p>The resident had a care plan focus for "General/Healthful diet" with</p>				

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	<p>interventions of:</p> <ol style="list-style-type: none"> 1. monitor lab values when available. 2. monitor weight and food and fluid intakes. 3. Regular diet with thin liquids. 4. 1500 ml fluid restriction, 960 ml provided by dietary and 540 ml provided by nursing. <p>Review of the daily fluid intakes for the resident indicated the resident's daily totals were as follows:</p> <p>5/1/12 - 2180 ml, this was 680 ml over the restriction 5/2/12 - 1820 ml, this was 320 ml over the restriction 5/3/12 - 1700 ml, this was 200 ml over the restriction 5/4/12 - 2920 ml, this was 1420 ml over the restriction 5/5/12 - 2400 ml, this was 900 ml over the restriction 5/6/12 - 2360 ml, this was 860 ml over the restriction 5/7/12 - 2480 ml, this was 980 ml over the restriction 5/8/12 - 2560 ml, this was 1060 ml over the restriction 5/9/12 - 2160 ml, this was 660 ml over the restriction 5/10/12 - 2320 ml, this was 820 ml over the restriction 5/12/12 - 2380 ml, this was 880 ml over the restriction 5/13/12 - 2040 ml, this was 540 ml</p>						

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	<p>over the restriction 5/14/12 - 1980 ml, this was 480 ml over the restriction 5/15/12 - 1740 ml, this was 240 ml over the restriction 5/16/12 - 2280 ml, this was 780 ml over the restriction 5/17/12 - 2180 ml, this was 680 ml over the restriction 5/18/12 - 1900 ml, this was 400 ml over the restriction 5/19/12 - 2160 ml, this was 660 ml over the restriction 5/20/12 - 1740 ml, this was 240 ml over the restriction.</p> <p>This resulted in the resident being over the daily fluid restriction for 19 of the 20 days reviewed in May, 2012.</p> <p>During an interview with the Dietary Manager on 5/21/12 at 3:30 p.m., she indicated dietary gives the resident a total of 960 ml's of fluid daily with her meals and nursing gives the resident 540 ml's of fluid.</p> <p>During an interview with the Director of Nursing on 5/21/12 at 4:55 p.m., she indicated the resident was non-compliant with the fluid restriction and requests to have a water pitcher in her room.</p> <p>The clinical record lacked any</p>				

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	<p>indication of the resident being non-compliant with the fluid restriction.</p> <p>During an interview on 5/22/12 at 10:15 a.m., the Director of Nursing indicated the facility had no policy related to fluid restrictions. She indicated she had just realized the night before there was no documentation related to the resident's non-compliance of fluid restrictions.</p> <p>3.1-37(a)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to ensure a resident received adequate oral care twice daily as indicated in the facility policy a recommended by the dentist for 1 of 3 residents reviewed of the 4 residents who met the criteria for oral health status. (Resident #101)</p> <p>Findings:</p> <p>1.) The clinical record for Resident #101 was reviewed on 5/16/12 at 10:16 a.m.</p> <p>Diagnoses for Resident #101 included, but were not limited to, dementia, hypothyroidism, and osteoporosis.</p> <p>A nursing admission observation note, dated 6/9/11, indicated Resident #101 required assistance with oral care.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 3/1/12, indicated Resident #101 was cognitively impaired. The assessment indicated</p>	F0312	<p>F 312: Corrective Actions taken for those residents affected by the alleged deficient practice: Care plan kardex report for resident #101 corrected to reflect oral/dental care needs. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by alleged deficient practice. Care plan kardex have been reviewed for all residents and corrected if indicated on or before 6/8/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: All resident kardex have been reviewed and updated to reflect oral/dental needs as necessary. An inservice on oral care and the kardex has been completed on or before 6/8/2012. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A Quality Assurance audit will be completed by the DON/designee on three residents per unit three times per week for proper oral care as well as appropriate information on kardex for three months, then monthly for three months, and then quarterly</p>	06/11/2012			

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	<p>she required extensive assistance from one staff member for personal hygiene needs.</p> <p>During a family interview on 5/15/12 at 4:00 p.m., Resident #101's family member indicated resident was not receiving the assistance she needs with brushing her teeth. The family member indicated the resident had been seen by the dentist and the dentist had indicated the resident was not receiving satisfactory oral care.</p> <p>A progress note from the dentist, dated 10/20/11, indicated resident had very heavy plaque. Dentist indicated resident's teeth needed to be brushed more often, at least two times a day.</p> <p>A progress noted from the dentist, dated 5/15/12, indicated oral care was not satisfactory and resident's teeth need to be brushed at least two times a day. The dentist referred resident to see an oral surgeon for an evaluation.</p> <p>The Care Plan Kardex Report (Certified Nursing Assistant assignment sheet), dated 5/17/12, lacked any information specific to oral/dental care twice daily.</p>		<p>there after. The results of the audit will be forwarded to the QA quarterly meeting for review and any concerns addressed. Completion Date: 6/11/2012</p>		

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	<p>Review of the current facility policy, dated 3/12, titled "Personal Hygiene," provided by the Director of Nursing on 5/22/12, at 10:15 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To ensure residents receive necessary care and assistance for personal hygiene tasks....</p> <p>...Policy:</p> <ol style="list-style-type: none"> 1. Personal hygiene will be performed 2 times daily in the morning and before bed. 2. Personal hygiene may include, but is not limited to: <ol style="list-style-type: none"> a. Oral care..." <p>3.1-38(a)(3)(C)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure behaviors requiring the need for antipsychotic medication use were identified and behavior monitoring was completed to ensure the medication was necessary for 1 of 10 residents reviewed for unnecessary medications. (Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident</p>	F0329	<p>F329: Corrective actions taken for those residents affected by the alleged deficient practice: Resident #19 clinical record has been reviewed and updated to reflect behaviors to monitor. Behavior monitoring implemented and dosage of medication was reduced by the physician. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents receiving antipsychotic medications have the potential to be affected by alleged deficient practice. Clinical records of all residents receiving</p>	06/11/2012	

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	<p>#19 was reviewed on 5/16/12 at 3:45 p.m.</p> <p>Diagnoses for Resident #19 included, but were not limited to mental retardation and episodic mood disorders.</p> <p>A health care plan problem, dated 5/16/12, indicated "Use of drugs having an altering effect on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems AEB [as evidenced by] decline mood/behavior, decline cognitive status." One of the approaches for this problem was "Observe resident mood state and behavior."</p> <p>The May 2012 recapitulation of physician's orders indicated Resident #19 received Risperidone (an antipsychotic medication) 0.5 milligrams twice daily for episodic mood disorders. The original date of this order was 3/20/12.</p> <p>The clinical record lacked any information related to the specific behaviors for which the medication was being given. The clinical record lacked any behavior monitoring information for Resident #19.</p>		<p>antipsychotic medications have been reviewed and corrected if necessary to include behaviors to observe for and behavior monitoring on or before 6/8/2012.</p> <p>Measures taken and systemic changes made to ensure the deficient practice does not recur:</p> <p>Clinical records of all residents receiving antipsychotic medications have been reviewed and updated. Newly admitted residents as well as new orders for antipsychotic medications are reviewed every business day by Social Services in order to identify specific behaviors for medication use with behavior monitoring implemented as necessary. Staff have been inserviced on behavior management on or before 6/8/2012. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be completed by Social Services every business day of physician orders for newly ordered antipsychotic medications for new and current residents with implementation of behavior monitoring as well as behaviors to observe for. Audit will be completed every business day and will be ongoing. The results will be forwarded to the quarterly QA meetings for review and any concerns addressed.</p> <p>Completion Date: 6/11/2012</p>		

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	<p>During an interview on with the Director of Nursing (DoN) and LPN #2 on 5/18/12 at 1:45 p.m., additional information was requested related to the specific behaviors the medication was being given for and any behavior monitoring being done.</p> <p>During an interview on 5/22/12 at 10:40 a.m., the Social Services Director indicated she had not identified the specific behaviors for which the antipsychotic medication was being given and no behavior monitoring was being done. She indicated Resident #19's need for the antipsychotic medication had not been reviewed by the Behavior Management Team.</p> <p>3.1-48(a)(4)</p>			

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F0441 SS=D	<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 - (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 and interview, the facility failed to ensure a CNA did</p>	F0441	F441: Corrective Actions taken for those	06/11/2012	

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	<p>not cross contaminate water pitchers when passing ice water for 2 of 2 residents observed receiving fresh ice water. (Resident #'s 34, 51 and CNA #3)</p> <p>Findings Include:</p> <p>During an interview with Resident #34 on 5/15/12 at 3:13 p.m., CNA #3 entered the room to give Resident #34 and Resident #51 fresh ice water. The CNA picked up the water pitcher off of Resident #34's bedside stand. She placed the pitcher against her chest and held it there against her uniform top with her left arm. She then retrieved Resident #51's water pitcher with her right hand and carried it by the top rim into the bathroom to empty them. She carried them from the bathroom to hall in the same manner. When she returned to the room she carried one water pitcher between her left arm and chest and the other by the rim of the pitcher. She removed the pitcher that had been against her uniform and placed it on Resident #34's bedside stand and placed the second pitcher on Resident #51's bedside stand.</p> <p>During an interview with the Director of Nursing on 5/21/12 at 4:30 p.m., she indicated water pitchers should</p>		<p>residents affected by the alleged deficient practice: Water pitchers for resident #34 and #51 replaced with clean pitchers. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents receiving ice water in water pitcher have the potential to be affected by alleged deficient practice. Staff inserviced on infection control and ice water pass on or before 6/8/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: All water pitchers for every resident have been replaced with clean pitcher. Staff inserviced on infection control and ice water pass on or before 6/8/2012. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A Quality Assurance audit will be completed by the DON/ designee to observe for infection control compliance during ice water pass on three resident/hall three times a week for three months, then monthly for three months, and then quarterly there after. The results will be forwarded to the QA quarterly meeting for the review and any concerns addressed. Completion date: 6/11/2012</p>				

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	<p>be emptied and filled one at a time so they do not get mixed and given to the wrong resident. She indicated the pitchers should be carried by the handles and not up against uniforms.</p> <p>3.1-18(b)(1)</p>				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure blood pressures and/or pulses were recorded when medication was withheld related to the readings for 2 of 10 residents reviewed for unnecessary medications. (Resident #56 and #82)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #56 was reviewed on 5/16/12 at 10:30 a.m.</p> <p>Diagnoses for Resident #56 included, but were not limited to, senile dementia, hypertension, and atrial fibrillation.</p> <p>Current physician's orders for</p>	F0514	<p>F514: Corrective Actions taken for those residents affected by the alleged deficient practice: Unable to correct for resident #56 or #82 as blood pressures or pulses are not available. Physician notified of withheld medications. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents receiving medication that require documentation of blood pressure and/or pulse have the potential to be affected by the alleged deficient practice. Physician orders for all residents receiving medications that require blood pressure or pulse documentation have been reviewed and clarifications made with the physician as needed. The electronic medication administration record has been updated where necessary to allow for documentation of blood pressure or pulse value when needed on or before 6/8/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: All ordered blood pressure and pulse</p>	06/11/2012	

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	<p>Resident #56 indicated the resident received Digoxin (a heart medication) 0.125 milligrams once daily. The order indicated the medication was to be held for a heart rate below 60. The original date of this order was 3/13/12.</p> <p>During a review of the April and May 2012 Medication Administration Records (MAR) for Resident #56, they indicated the Digoxin medication was held on the dates noted below:</p> <p>April 1, 4, 5, 6, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 23, 24, 25, 27, 28, 29, and May 1, 2, 4, 7, 8, 9, 12, 13, 14, and 15, 2012.</p> <p>The space designated on the MAR to record the pulse reading was left blank on all of the above dates.</p> <p>During an interview on 5/21/12 at 4:30 p.m., the Director of Nursing (DoN) indicated the nursing staff are supposed to document the pulse readings on the MAR and the computer program would be changed and a prompt added which would required them to record the pulse.</p> <p>2.) Resident #82's clinical record was reviewed on 5/21/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to, peripheral</p>		<p>medications have been reviewed and electronic medication administration record have been updated to allow for accurate documentation of blood pressure and pulse when needed and staff inserviced on or before 6/8/2012 . How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A Quality Assurance audit will be completed by the DON/designee for documentation of blood pressure and/ or pulse in the residents electronic medical record on three residents per unit three times a week for three months, monthly for three months and then quarterly there after. The results of the audit will be forwarded to the QA quarterly meeting for review and any concerns addressed. Completion Date: 6/11/2012</p>		

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	<p>vascular disease, senile dementia, essential hypertension, and hyperlipidemia.</p> <p>The resident had 5/2/12, signed Physician's Orders. The orders included, but were not limited to, Cardizem [a blood pressure medication] 60 mg [milligram] by mouth three times a day and hold the medication if the systolic blood pressure is less than 90 or the heart rate is less that 60. Clonidine HCL [a blood pressure medication] 1 mg by mouth three times a day and hold for a systolic blood pressure less than 100. Metoprolol succinate [a blood pressure medication] 50 mg by two times a day and to hold if the pulse is below 60.</p> <p>Review of the April, 2012, Medication Administration Record [MAR] and clinical recorded lacked a documented blood pressure and pulse on the following dates and times: 4/1/12 at 4:00 p.m. 4/2/12 at 8:00 a.m. 4/4/12 at 8:00 a.m. and 12:00 p.m. 4/5/12 at 12:00 p.m. and 4:00 p.m. 4/6/12 at 4:00 p.m. 4/10/12 at 4:00 p.m. 4/13/12 at 4:00 p.m. 4/16/12 at 4:00 p.m.</p>						

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	<p>4/20/12 at 8:00 a.m., 12:00 p.m. and 4:00 p.m. 4/22/12 at 4:00 p.m. 4/27/12 at 4:00 p.m.</p> <p>This resulted in the blood pressure and pulse not being documented 15 out of 150 times for the month of April 2012.</p> <p>Review of the May, 2012, Medication Administration Record and clinical record lacked a documented blood pressure and pulse on the following dates and times: 5/2/12 at 12:00 p.m. 5/4/12 at 12:00 p.m. and 4:00 p.m. 5/6/12 at 4:00 p.m. 5/7/12 at 4:00 p.m. 5/10/12 at 12:00 p.m. there was a pulse recorded, but no blood pressure recorded. 5/14/12 at 4:00 p.m.</p> <p>This resulted in the blood pressure and/or pulse not being documented 7 out of 63 times for the time period of 5/1 through 5/21/12.</p> <p>During an interview on 5/21/12 at 4:30 p.m., the Director of Nursing (DoN) indicated the nursing staff are supposed to document the pulse readings on the MAR and the computer program would be changed</p>						

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	<p>and a prompt added which would required them to record the pulse.</p> <p>3.) Review of the current facility policy, dated 1/12, titled "Documentation Procedure and Guidelines," provided by the Director of Nursing on 5/22/12, at 10:15 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <ol style="list-style-type: none"> 1. To reflect the quality of care provided to each resident. 2. To document the resident's progress toward care plan goals, interventions and responses to treatment.... <p>...General Guidelines:...</p> <ol style="list-style-type: none"> ...3. Any change in condition, will require a written evaluation. 4. Medication administration, Treatment administration, and CNA documentation will be entered electronically into the Resident's Medical record.... <p>...Nursing Documentation:...</p> <ol style="list-style-type: none"> ...3. Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner.... ...7. Verbal and telephone 						

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	<p>communication with all parties concerning the care and treatment of the resident will be entered in the clinical record...."</p> <p>3.1-50(a)(1)</p>				