STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155686	A. BUILDING 00 B. WING	11/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-KNOX	300 E CULVER RD KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00184899. This visit was in conjunction with the investigation of Complaint IN00185778. Complaint IN00184899- Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey dates: October 26, 27, 28, 29, 30, and November 2, 2015 Facility number: 000088 Provider number: 155686 AIM number: 100289260 Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 5 Medicaid: 38 Other: 8 Total: 51 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000	Preparation, submission and implementation of this plan does not constitute an admission or agreement of, or agreement with the facts and conclusions set forth on this survey report. This Plan of Correction is prepared and excuted as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1. Quality review completed by 26143, on November 6, 2015.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow a Physician's Order to hold a medication prior to a resident's surgery for 1 of the 19 residents Physician's Orders reviewed. (Resident #11) Finding includes: Record review for Resident #11 was completed on 10/28/15 at 9:30 a.m. The residents diagnoses included, but were not limited to, heart failure and atrial fibrillation. Review of a Physicians preoperative instructions dated on 9/25/15, indicated the resident was to have cataract surgery on 10/21/15. The physician instructed the resident's Coumadin (blood thinning medication) be discontinued on 10/17/15	F 0282	**1) Resident #11's physician was notified on 10/20/2015 that Coumadin was not held as ordered prior to scheduled cataract surgery. Surgery was rescheduled. No harm noted to the resident. 2) An audit of all residents' current Physician orders were reviewed to ensure medicatons are given based on individual physician orders. No other residents were affected by this practice. Care Plans were reviewed and adjustments made as appropriate. 3) Licensed nurses were in-serviced on correct electronic inputting and follow physician orders along with appropriate care plans. New physician orders will continue to be reviewed as part of Clinical Start Up process including review or revision of appropriate care plan by DNS**	12/02/2015

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	and be restarted on 10/22/15. Review of a Physician Progress Note dated 10/15/15 indicated the resident was having upcoming surgery and to hold the Coumadin 5 days prior. Review of the October 2015 Physician Order Summary (POS) indicated an order for Coumadin 2 mg (milligrams) every day. Review of the October 2015 MAR (Medication Administration Record) indicated the resident received the Coumadin every day prior to the surgery date of 10/21/15. A Progress Note dated 10/20/15 at 2:45 p.m., indicated the resident had been taking the Coumadin and the doctors office was called about rescheduling her surgery. A Progress Note dated 10/20/15 at 11:07 p.m., indicated the residents surgery had been canceled. Interview with the Interim DON (Director of Nursing) on 10/28/15 at 2:18 p.m., indicated the resident's Coumadin should have been held before the surgery date according to the Physician's Orders.		**or Designee as part of the Clinical Start Up process. 4) An audit tool referred to as Clinical Start Up to monitor physician orders and care plans will be completed by the DNS or designee 5 times per week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 8 weeks, then monthly for 8 weeks. 5) Audit results will be reviewed during the QAPI process to provide redirection or change when necessary and dictate continuation or completion of the monitoring process based on compliance.**	

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	3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	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. Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to assessment upon return from dialysis for 1 of 2 residents reviewed for Dialysis of the 3 residents who met the criteria for Dialysis. (Resident #B) Finding includes: Resident #B's record was reviewed on 10/28/15 at 8:51 a.m. Diagnoses included, but were not limited to, profound intellectual disabilities, end stage renal disease, dementia without behavioral disturbance, and major depressive disorder. Review of current Physician Orders included the following: Resident to have Hemodialysis at Dialysis Center on	F 0309	**1) Resident B was discharged from the living center on 10/16/2015.** **2) All resident receiving hemodialysis have the potential to be affected by the alleged deficient practice. All dialysis residents were reviewed with no adverse findings.** **3) Licensed nurses were in-serviced on pre / post hemodialysis assessments including documentation of assessment on dialysis communication form.** **4) An audit tool will be completed by the DNS or designee 5 times per week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 8 weeks, and then monthly for 8 weeks. Audit results will be reviewed during the QAPI process to provide redirection or**	12/02/2015

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	Mondays, Wednesdays and Fridays. Review of care plans indicated the following pertaining to dialysis: - At risk for complications r/t (related to) dialysis therapy. Interventions included, but were not limited to, notify MD (physician) with any changes in condition, and observe for dialysis hangover after dialysis to include nausea, headache weakness. - Risk for infection or bleeding from access site r/t shunt for dialysis. Interventions included, but were not limited to, monitor for signs of bleeding/ hematuria, bleeding gums, tarry stools, bruising, edema, weight gain, or changes in blood pressure; notify MD with any abnormal's or changes in condition; and observe for s/sx (signs/ symptoms) of infection at fistula site. Review of Resident #B's Dialysis Communication book from July 2015 through October 28, 2015 lacked a post dialysis assessment completed on the following dates: 10/23/15, 10/19/15, 9/18/15, 8/31/15, 8/28/15, 8/24/15, 8/21/15, 8/7/15, 8/5/15, 8/3/157/29/15, 7/27/15, 7/24/14, 7/22/15, 7/20/15, 7/15/15, 7/10/15, 7/1/15. The charting also lacked a pre and post dialysis assessment on 7/17/15 and 7/13/15.		**change when necessary and dictate continuation or completion of the monitoring process based on compliance.**	

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	Review of Progress Notes lacked any documentation of pre and post dialysis assessments completed. Interview with LPN #1 on 10/28/15 at 10:02 a.m., indicated nurses were supposed to document a post dialysis assessment after every dialysis session on the forms kept in resident's dialysis binders. Interview on 10/28/15 3:29 p.m. with the DON (Director of Nursing), indicated nurses were to document post dialysis assessments on the back of the Dialysis Observation/ Communication Form kept in the resident's dialysis binder after every dialysis session. A policy titled "Dialysis Guideline" was provided by the DON on 10/28/15 and deemed as current. The policy indicated, " .... Post Dialysis Protocol: Review transfer forms or UDA documents for any pertinent information; Observe for unusual symptoms such as lethargy, chest pain, headache, unsteady gait or nausea ...." This Federal tag relates to Complaint IN00184899. 3.1-37(a)			

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F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to ensure an admission assessment was completed for a resident with pressure ulcers for 1 of 3 residents reviewed for pressure ulcers of the 3 who met the criteria for pressure ulcers. (Resident #30) Finding includes: Resident #30's closed record was reviewed on 10/29/15 at 2:20 p.m. The residents diagnoses included, but were not limited to, diabetes, chronic kidney disease, hypertension, and osteomyelitis (bone infection). A Direct Charting Flow Sheet completed	F 0314	**1) Resident #30 was discharged from the living center on 9/10/2015.** **2) All newly admitted residents have the potential to be affected by the alleged deficient practice. All new admissions were reviewed for the last 30 days for documentation of all pressure ulcers present on admission with orders in place for appropriate treatments. No deficiencies were noted.** **3) Licensed nurses were in-serviced on appropriate documentation of all pressure ulcers on the admission assessment.** **4) An audit tool will be**	12/02/2015

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	at the hospital before the resident was admitted to the facility indicated: 8/9/15: covered sore on bilateral (both) buttocks 8/10/15: covered sore on bilateral buttocks 8/12/15: scabbed area to right toe 8/17/15: stage 2 to buttock 8/20/15: pressure sore to coccyx Resident #30 was admitted to the facility on 8/21/15 from the hospital. The Clinical Health Status Admission Assessment completed on 8/21/15, indicated the resident was admitted with the start of a stage 1 pressure ulcer to the left buttock that measured 2 cm (centimeters). The illustration of the body had an arrow pointing to the right buttock which indicated a pressure ulcer. A Physicians Order dated 8/21/15 and started 8/22/15 indicated Bacitracin Zinc Ointment (topical ointment) to be applied to the right buttock topically every day and evening shift for a stage 2 pressure ulcer. A Progress Note completed on 8/27/15 at 2:33 p.m., indicated: NAR (Nutrition At Risk): resident was a new admit and had a stage 1 to coccyx and a stage 2 to the right lower buttock which measured 0.3		**completed by the DNS or designee to review all new admissions assessments to ensure all pressure ulcers are documented with appropriate treatments in place 5 times a week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 8 weeks. Audit results will be reviewed during the QAPI process to provide redirection or change when necessary and dictate continuation or completion of the monitoring process based on compliance.**	

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	cm x 0.8 cm. The resident had 3 stage 2 wounds to the left buttock. The first wound measured 0.5 cm x 2.0 cm; the second wound measured 1.0 cm x 2.5 cm; and the third wound measured 2 cm x 1.5 cm. The resident had an order for a petroleum sacral dressing change every 3 days to all areas of the buttocks. The resident also had a scab to the right great toe which measured 0.3 cm x 0.3 cm. A Progress Note completed on 8/28/15 at 8:29 a.m., indicated the Bacitracin Zinc Ointment treatment to the buttocks was discontinued and the resident had a new treatment order for petroleum dressing to be changed every 3 days. The resident was also to have an order to continue with the Bacitracin Zinc Ointment to the area of the right great toe. The Admission Minimum Data Set (MDS) assessment completed on 8/28/15 indicated the resident had 1 stage 1 pressure ulcer, 4 stage 2 pressure ulcers, and 1 unstageable pressure ulcer that were all present on admission. The record lacked any indication the pressure ulcers the resident was admitted with on 8/21/15 from the hospital were assessed and measured until 8/27/15. An interview with the Interim DON			

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	(Director of Nursing) on 11/2/15 at 2:10 p.m., indicated the resident was admitted to the facility from the hospital with all the pressure ulcers to the buttocks and the toe. She indicated a complete assessment including measurements of the wounds should have been completed when the resident was admitted. She further indicated the pressure ulcers had a treatment in place and the order should have reflected each area specifically to be treated. A facility policy, titled Skin Integrity Guideline, and received as current form the Interim DON on 10/30/15 at 1:45 p.m., indicated..." Documentation and Care Intervention for Skin Integrity: Evaluation/Observation is to be completed within the first twenty-four hours of admission/quarterly/significant change of condition using the Clinical Health Status Tool...." 3.1-31(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates			

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	that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident with an indwelling urinary catheter received the necessary care and services to prevent a urinary tract infection for 1 of 1 residents reviewed for urinary catheter use of the 4 residents who met the criteria for urinary catheter use. (Resident #B) Finding includes: On 10/28/15 at 9:42 a.m., Resident #B was observed returning from dialysis via gurney. The transport staff tossed his catheter bag on the floor and proceeded to transfer the resident to his bed, leaving the catheter bag on the floor by the bed. On 10/28/15 9:48 a.m. LPN #1 entered Resident #B's room, talked to the resident, washed her hands, donned gloves, and proceeded to place Resident #B's catheter bag in a dignity bag hanging from the side of the bed and off the floor. She indicated at the time the transport staff does not usually leave the resident's catheter bag on the floor and should not have done so.	F 0315	**1) Resident #B was assessed for presence of a urinary tract infection. No symptoms were noted.** **2) All residents with Foley catheters have the potential to be affected by the alleged deficient practice. All residents with Foley catheters were assessed for signs and symptoms of urinary tract infection. No signs or symptoms were noted.** **3) Licensed nurses, therapy staff and certified nursing assistants were in-serviced on correct placement of Foley catheter bag and Foley catheter tubing to reduce potential urinary tract infection risk. EMS personnel were in-serviced on correct placement of Foley catheter bag and Foley catheter tubing to reduce potential urinary tract infection risk.** **4) An audit tool will be completed by the DNS or designee to observe all residents with Foley catheters for correct placement of Foley catheter bag and Foley catheter tubing 5 times per week x 4 weeks, then 3 times per week for**	12/02/2015

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	On 10/28/15 at 11:13 a.m., Resident #B was observed propelling himself in his wheelchair to the main dining room. His catheter tubing was observed to be dragging on the floor down the hallway. On 10/28/15 at 2:23 p.m., Resident #B was observed in his wheelchair in the main dining room playing BINGO. He was rolling his wheelchair back and forth at the table and his catheter tubing was observed sliding back and forth directly on the floor. On 10/28/15 at 2:52 p.m., Resident #B was observed self propelling his wheelchair in the hallway by the lobby. His catheter was observed to be dragging on the floor. Interview on 10/28/15 at 2:56 p.m. with LPN #2, indicated urinary catheter tubing should not be on the floor and the CNAs should definitely be aware of that when they help transfer residents from bed to wheelchair. Interview on 10/28/15 at 2:57 p.m. with CNA#2, indicated Resident #B was an extensive assist of one staff member with transfers and did not transfer himself from his bed to his wheelchair.		**4 weeks, then weekly for 8 weeks, then monthly for 8 weeks. Audit results will be reviewed during the QAPI process to provide redirection or change when necessary and dictate continuation or completion of the monitoring process based on compliance.**	

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	Interview on 10/29/15 at 8:50 a.m. with the Clinical Educator, indicated she was aware of the issue with Resident #B's catheter bag involving the transport service and had contacted the transport service to address the issue to ensure their staff did not place a resident's urinary catheter or tubing on the floor. Resident #B's record was reviewed on 10/28/15 at 8:51 a.m. Diagnoses included, but were not limited to, profound intellectual disabilities, end stage renal disease, dementia without behavioral disturbance, major depressive disorder, and neuromuscular dysfunction of bladder. A Quarterly MDS (Minimum Data Set) assessment dated 9/4/15 indicated the resident was cognitively intact, had an indwelling catheter and was an extensive, one person physical assist for transfers, using a wheelchair for locomotion. Review of care plans indicated a care plan for risk for complications r/t (related to) suprapubic (indwelling) catheter including pain, obstruction, infection or tissue injury. A policy titled "Suprapubic Catheter ..." was provided by the DON (Director of Nursing) on 10/29/15 and deemed as			

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	current. The policy indicated, ".... Properly position bag below level of bladder (must not touch floor) and secure to bed frame ...." 3.1-41(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment free from hazards related to unsafe hot bathroom water temperatures and a frayed electrical call button for 3 of the 30 residents whose rooms observed. (Residents #11, #66, and #25) Findings include: 1. On 10/26/15 at 1:55 p.m., the shared bathroom for Residents #11 and #66 was observed and the water from the bathroom sink felt extremely warm to	F 0323	1: Temperature for Residents # 11 and #66 adjusted immediately. Maintenance Director monitored the water temperatures for the above mentioned Residents throughout the day and temperatures remained within acceptable range. Call light cord replaced immediately for Resident #25. 2: All resident rooms and resident areas were tested for proper temperature range. All Staff In-Service initiated regarding water in resident areas that appear to be warmer than normal. Circulator Pump and Cartridge Mixing Valve replaced 10-27-2015 to allow increased water flow and	12/02/2015

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GOLDEN LIVING CENTER-KNOX	300 E CULVER RD KNOX, IN 46534

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	touch. The water temperature was measured by the Maintenance Director at 1:58 p.m. and found to be 135.5 degrees. He proceeded to test the temperatures of the water in the surrounding rooms and all were within safe range. Interview with the Maintenance Director at the time of the observation indicated the water temperature should be 120 degrees or below and he liked to keep it around 112-114 degrees. He further indicated he would adjust the mixing valve immediately and continue to monitor temperatures. He also indicated his water temperature monitoring procedure included checking the temperatures of the closest and furthest rooms on each wing every morning and entering the results into the facility's maintenance computer program. Resident #11's record was reviewed on 10/26/15 at 2:30 p.m. A quarterly MDS (Minimum Data Set) assessment dated 9/11/15 indicated she was mildly cognitively impaired. Resident #66's record was reviewed on 10/26/15 at 2:35 p.m. A quarterly MDS assessment dated 8/26/15 indicated she was cognitively impaired. A screenshot of the computerized		temperature management. Audit of all resident call lights completed on 11-16-2015 with no additional findings. 3: Maintenance or Designee will complete random water checks throughout the building 5 times weekly for two weeks, then 3 times weekly for two weeks, then 1 time weekly for two weeks until consistent water temperatures are documented. Additionally, Maintenance Director or Designee will complete water temperature checks in room 11, room 5 and rooms in close proximity, 3 times daily for 2 weeks, then 2 times daily for 4 weeks until consistent water temperatures are documented. Resident room call light cord audit will be completed 2 times month via Guardian Angel Program and any concerns will be reported to Maintenance Director via Building Engine Program for repair. 4: Outcome of water temperature checks and call light cord audits will be reviewed in QAPI for 6 months. If no negative findings, monitoring for call light cords will continue per monthly Guardian Angel Program. Monitoring for water temperatures will continue monthly via the Building Engine Monitoring Program.	

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	Preventative Maintenance Schedule Equipment Task List was provided by the Administrator on 10/27/15 at 2:10 p.m. At that time, she indicated this was the procedure used by the facility. The task list indicated for the Maintenance Director to check and record the water temperatures daily in the following areas: water heater, first and last rooms of each wing, shower and bathing areas, dietary/ laundry water heater, dietary sink, and laundry area. The Administrator indicated she received an email alert if values outside the 100-120 degree range were recorded for the resident rooms. 2. Resident #25's room was observed on 10/26/15 at 1:47 p.m. At that time, the call button by her bed was within her reach and noted to have exposed wires to the area between the long cord and the hand-held push button. Interview with CNA #1 on 10/26/15 at 1:49 p.m., indicated Resident #25 was capable of using her call button. During the environmental tour on 10/29/15 beginning at 3:00 p.m. with the Administrator, Maintenance Director, and Housekeeping & Laundry Supervisor, Resident #25's call light was observed within her reach in her wheelchair and with exposed wires			

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	between the cord and hand-held push button. Interview with the Administrator and Maintenance Director at the time of the observation indicated the exposed wires were a safety hazard and the call light cord would be replaced immediately. Resident #25's record was reviewed on 10/29/15 at 3:50 p.m. A quarterly MDS dated 8/28/15 indicated the resident was cognitively impaired. 3.1-45(a)(1)			
F 0329 SS=D Bldg. 00	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. 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			

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	residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure Pharmacy recommendations were implemented in a timely manner related to a gradual dose reduction for a resident receiving an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 1) Findings include: The record for Resident #1 was reviewed on 10/28/15 at 8:43 a.m. The resident's diagnoses included, but were not limited to, depression, seizures, Parkinson's Disease and anxiety. Review of the Pharmacy recommendation dated 7/27/15, indicated the resident had been receiving two antidepressant medications concurrently, Lexapro 10 mg (milligrams) and desipramine 100 mg twice a day. The recommendation indicated the medications may be considered duplicate therapy and contribute to polypharmacy and unnecessary medication use with an increased risk of side effects. The Pharmacy recommended to discontinue desipramine due to potential adverse	F 0329	**1) Resident #1 was assessed for side effects of antidepressant medications. None were noted.** **2) All residents receiving antidepressant, antianxiety, hypnotic and psychotropic medications have the potential to be affected by the alleged deficient practice. All Consultant Pharmacist Recommendations for the last 30 days were reviewed to ensure they were addressed with the physician as recommended. No deficiencies were noted** **3) Licensed nurses were in-serviced on procedure for addressing the monthly Consultant Pharmacist Recommendations.** **4) An audit tool will be completed by the DNS or designee to review all Consultant Pharmacist Recommendations for follow-up as recommended 5 times a week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 8 weeks. Audit results will be reviewed during the QAPI process to provide redirection or change when necessary and dictate continuation or completion of the monitoring process based on**	12/02/2015

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	effects and ineffective (sic). The Physician responded by writing "psych ? with (the psychiatrists name)" on the Pharmacy recommendation. A sticky note dated 8/4/15 attached to the recommendation indicated the Physician wanted "psych to handle these". The Physician Order Summary for October 2015 indicated the resident was to have received Lexapro 10 mg daily and desipramine 100 mg twice a day. The October Medication Administration Record indicated the resident had received the Lexapro 10 daily and the desipramine 100 mg twice a day. Interview with the Social Services Director on 10/28/15 at 3:33 p.m. indicated the Pharmacy recommendations had not been given to the FNP (Family Nurse Practitioner). An interview with the FNP on 10/28/15 at 3:45 p.m., indicated she had not received the Pharmacy recommendation and would have reduced the antidepressant medication at that time. The policy titled, "Medication Monitoring, Documentation and Communication of Consultant		**compliance.**	

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	Pharmacist Recommendations," was provided by the Interim Director of Nursing on 20/19/15 at 10:30 a.m., indicated, "...Procedures...B. Comment and recommendations concerning medication therapy are communicated in a timely fashion...." 3.1-25 (j)			
F 0354 SS=C Bldg. 00	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to have an RN present in the building , for at least 8 consecutive hours a day for 1 day out of 14 days	F 0354	**1) No residents were identified as affected** **2) No residents were affected by**	12/02/2015

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	reviewed. Findings include: On 10/29/15 at 11:52 a.m. a review of the nursing schedules dated October 14, 2015 through October 28, 2015, indicated there was not an RN scheduled in the facility for 8 consecutive hours on October 18, 2015. During an interview with the Administrator on 10/29/15 at 1:59 p.m., she indicated there was not an RN scheduled for that day, only "on-call". The Administrator further indicated there was not a policy for an RN to be in the building for 8 consecutive hours daily. 3.1-17(b)(3)		**the alleged deficient practice.** **3) RN coverage will be reviewed by the Director of Nursing Services and Executive director to ensure RN coverage.** **4) An audit tool will be completed by the DNS or designee to review RN coverage to ensure 8 consecutive hours per day are provided 5 times a week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 8 weeks. Audit results will be reviewed during the QAPI process to provide redirection or change when necessary and dictate continuation or completion of the monitoring process based on compliance.**	
F 0428 SS=D Bldg. 00	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			

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	Based on record review and interview, the facility failed to ensure Pharmacy recommendations were implemented in a timely manner related to a gradual dose reduction for a resident receiving an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 1) Findings include: The record for Resident #1 was reviewed on 10/28/15 at 8:43 a.m. The resident's diagnoses included, but were not limited to, depression, seizures, Parkinson's Disease and anxiety. Review of the Pharmacy recommendation dated 7/27/15, indicated the resident had been receiving two antidepressant medications concurrently, Lexapro 10 mg (milligrams) and desipramine 100 mg twice a day. The recommendation indicated the medications may be considered duplicate therapy and contribute to polypharmacy and unnecessary medication use with an increased risk of side effects. The Pharmacy recommended to discontinue desipramine due to potential adverse effects and ineffective (sic). The Physician responded by writing "psych ? with (the psychiatrists name)"	F 0428	**1) Resident #1 was assessed for side effects of antidepressant medications. None were noted.** **2) All residents receiving antidepressant, antianxiety, hypnotic and psychotropic medications have the potential to be affected by the alleged deficient practice. All Consultant Pharmacist Recommendations for the last 30 days were reviewed to ensure they were addressed with the physician as recommended. No deficiencies were noted.** **3) Licensed nurses were in-serviced on procedure for addressing Consultant Pharmacist Recommendations.** **4) An audit tool will be completed by the DNS or designee to review all Consultant Pharmacist Recommendations for follow-up as recommended 5 times a week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 8 weeks, then monthly for 8 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting.**	12/02/2015

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	on the Pharmacy recommendation. A sticky note dated 8/4/15 attached to the recommendation indicated the Physician wanted "psych to handle these". The Physician Order Summary for October 2015 indicated the resident was to have received Lexapro 10 mg daily and desipramine 100 mg twice a day. The October Medication Administration Record indicated the resident had received the Lexapro 10 daily and the desipramine 100 mg twice a day. Interview with the Social Services Director on 10/28/15 at 3:33 p.m. indicated the Pharmacy recommendations had not been given to the FNP (Family Nurse Practioner). An interview with the FNP on 10/28/15 at 3:45 p.m., indicated she had not received the Pharmacy recommendation and would have reduced the antidepressant medication at that time. The policy titled, "Medication Monitoring, Documentation and Communication of Consultant Pharmacist Recommendations," was provided by the Interim Director of Nursing on 20/19/15 at 10:30 a.m., indicated, "...Procedures...B. Comment			

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	and recommendations concerning medication therapy are communicated in a timely fashion...." 3.1-25 (j)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to dirty bathroom call light pull cords, stained privacy curtains, missing toilet screw covers, cracked sink caulk, loose and jagged door protectors, gouged doors, and a loose and protruding door jamb on 2 of 2 units throughout the facility. (West and East wings) Findings include: An Environmental tour was conducted on 10/29/15 beginning at 3:00 p.m. with the Administrator, Maintenance Director, and Housekeeping & Laundry Supervisor. The following were	F 0465	1: New Bathroom call light cords ordered and replaced on 11-02-2015. Toilet screw covers ordered and will be installed upon receipt for Rooms numbered 2, 21, and 25. Sink caulking for Room # 2 scraped and reapplied. Privacy curtain replaced immediately in Rooms 12 and 25. Entry door jam wood in Room 25 repaired immediately. Door covers will be replaced for Room numbers 12, 26 and 32. 2: Audit to be completed on in all resident rooms for bathroom sink caulking, toilet screw covers, entry door jams, and door protector covers. Any identified repair concerns will be entered into Building Engine Program for repair scheduling. Audit completed on privacy curtains and any stained curtains replaced	12/02/2015

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	observed: 1. West Wing a. Room 1: The bathroom call light pull cord was discolored. Two residents shared this bathroom. b. Room 2: The bathroom call light pull cord was discolored, the toilet screws were uncovered, and the sink caulk was cracked. Two residents shared this bathroom. c. Room 4: The bathroom call light pull cord was discolored. Two residents shared this bathroom. d. Room 11: The bathroom call light pull cord was discolored. Two residents shared this bathroom. e. Room 12: The bathroom call light pull cord was discolored, the inner bathroom door was gouged, and the privacy curtain between the beds was stained. Two residents resided in this room. f. Room 20: The bathroom call light pull cord was discolored. One resident used this bathroom. 2. East Wing		by Housekeeping Department. 3: Bathroom call light cords, bathroom sink caulking, toilet screw covers, entry door jams, door protectors and privacy curtains will be audited 2 times monthly via the Guardian Angle Program. Any Privacy curtain or soiled bathroom call light cord concerns will be reported to the Housekeeping Supervisor for cleaning. Any door jam, door protector, toilet screw cover or bathroom sink caulking concerns will be reported to the Maintenance Director via the Building Engine Program for repair. 4: Outcome of bathroom call light cords, bathroom sink caulking, toilet screw covers, entry door jams, door protectors and privacy curtain audits will be reviewed in QAPI for 6 months. If no negative findings, monitoring will be completed per monthly Guardian Angel Program.	

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	a. Room 21: The bathroom call light pull cord was discolored and the toilet screws were uncovered. Two residents shared this bathroom. b. Room 22: The bathroom call light pull cord was discolored. Two residents shared this bathroom. c. Rooms 23/24: The bathroom call light pull cord was discolored. Four residents shared this bathroom. d. Room 25: The bathroom call light pull cord was discolored, the toilet screws were uncovered, the entry door jamb wood was loose and protruding, and the privacy curtain between beds B & C was stained. Three residents resided in this room. e. Room 26: The bathroom call light pull cord was discolored and the outer bathroom door protector was loose. Two residents resided in this room. f. Room 27: The bathroom call light pull cord was discolored. One resident used this bathroom. g. Room 32: The bathroom call light pull cord was discolored and the inner bathroom door protector was loose and jagged. One resident resided in this			

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	room. h. Room 35: The bathroom call light pull cord was discolored. Two residents shared this bathroom. The Administrator indicated at the time of the tour all of the above were in need of cleaning or repair. 3.1-19(f)			