DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING _____ B. WING _____	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

(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 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure survey. Survey Dates: January 9, 10, 11, 12, 2012 Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 Survey Team: Linda Campbell, RN, TC Janet Stanton, RN Rita Mullen, RN Michelle Hosteter, RN (January 9, 11, 12, 2012) Heather Lay, RN Census Bed Type: SNF/NF: 168 NCC: 28 Total: 196 Census Payor Type: Medicare: 4 Medicaid: 130 Other: 62 Total: 196 Sample: 26 NCC Sample: 5 Supplemental Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 1/18/12 Cathy Emswiller RN	F 000		
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Dunn — TITLE: Administrator — (X6) DATE: 1/31/12

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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F000C	This visit was for a Recertification and State Licensure survey. Survey Dates: January 9, 10, 11, 12, 2012 Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 Survey Team: Linda Campbell, RN, TC Janet Stanton, RN Rita Mullen, RN Michelle Hosteter, RN (January 9, 11, 12, 2012) Heather Lay, RN Census Bed Type: SNF/NF: 168 NCC: 28 Total: 196 Census Payor Type: Medicare: 4 Medicaid: 130 Other: 62 Total: 196 Sample: 26 NCC Sample: 5 Supplemental Sample: 4	F0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	

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

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 1/18/12 Cathy Emswiller RN		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F0156 SS=D	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;	F0156		

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance			

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	directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to have a resident or a resident's authorized representative sign acknowledgement of a Do Not Resuscitate [DNR] Order. The deficient practice impacted 2 of 26 residents reviewed. [Resident #35 and Resident #131]. Findings include: 1. On 1-10-12 at 9:35 A.M., Resident #35's record was reviewed. Diagnoses included, but were not limited to, dementia, depression, anxiety, and osteoporosis. The resident's chart was flagged as DNR [Do Not Resuscitate]. A "Physician's Progress Notes" dated 9-19-11, no time, included, but was not limited to, "This member [Resident #35] should remain a full code at this point..."		**1. What action was taken to correct the deficient pract for affected residents? Families and MD notified immediately for two residents involved in reported incident 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All charts were audited facility wide to determine what the code status was on each resident b) Any resident with a DNR was issued a new DNR consent form and if cognitively intact, signed the consent after education from the social worker and MD. If unable to sign the form themselves, a certified copy of the consent form was mailed to the patients legal rep or POA to sign for them and the representative was educated c) The MD signed the new DNR consent form acknowledging the patient was a DNR and no code**	02/15/2012

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	A "Physician's Orders" dated 9-19-11, no time, included, "This member should remain a no code for now." There was not a "Do Not Resuscitate" signed acknowledgement in the clinical record. During exit conference on 1-10-12 at 3:00 P.M., the Director of Nursing and Administrator were asked for the "Do Not Resuscitate" signed acknowledgement from the resident or the resident's authorized representative. On 1-11-12 at 8:30 A.M., the Director of Nursing provided a document titled "Timeline on [Resident #35]: Regarding falls and interventions" this document included a written statement from the Director of Nursing regarding Resident #35's signed DNR acknowledgement, "We do not have patients or guardians/POA's [Power of Attorneys] sign consent forms." The Director of Nursing did not provide a copy of the acknowledgement. In an interview on 1-11-12 at 9:15 A.M., the Administrator indicated the Director of Nursing was not correct regarding DNR's. She indicated all residents that have a "Do Not Resuscitate" order must have the State of Indiana signed		**blue and had been educated, or the family if that was the case 3. What measures or systemic changes were put into place to be sure this does not reoccur? a) The DNR consent forms will be gone over upon admission with each new resident, or the guardian, by the social worker and the MD, as well as upon readmission from the hospital, and all parties will sign at that time 4. How will corrective actions be monitored? a) The Nursing Unit Manager will audit each new admission chart within 24 hours of admission to assure DNR form is in place and signed on chart by resident/and or guardian as well as physician and report to QA b) The Nursing Unit Manager will audit all charts on the unit monthly for appropriate DNR consents, signatures and supportive documentation weekly x 30 days, monthly x 3 months then quarterly thereafter and report results to QA 5. Changes will be complete by 2-15-12**	

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	document, "Out of Hospital Do Not Resuscitate Declaration and Order." 2. The clinical record for Resident #131 was reviewed on 1/11/12 at 1:35 P.M. A physician's order, dated 4/26/10 at 4:20 P.M., indicated "Member has been designated as a DNR [Do Not Resuscitate] (No Code)." A consent or acknowledgement, signed by the resident or other legal responsible party, selecting the choice of DNR, was not in the resident's clinical record. In an interview during the daily conference on 1/11/12 at 3:00 P.M., the Director of Nursing indicated information related to "Advanced Directives" was obtained from residents upon admission, but did not include getting a signature from the resident or responsible party designating a "Code" status. On 1-11-12 at 9:30 A.M., the Administrator provided the policy and procedure for Advanced Directives, dated 2/21/06 with an attached copy of the "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order." The policy and procedure included, but was not limited to, "Rationale: To establish guidelines to assure each resident is			

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	provided information on advanced directives in accordance with state laws... Policy: It is the policy of the [Facility] to allow the resident, authorized legal representative or next of kin to make decisions regarding health care..." 3.1-4(f)(4)(A)			

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F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure a resident's restraint was assessed related to a seat belt for 1 of 2 residents with restraints in a sample of 26. (Resident #60). Findings include: On 1/9/12 at 9:30 A.M. during an initial tour with ADON #7 (Assistant Director of Nursing), Resident #60 was identified as having had falls and having no restraints. On 1/11/12 at 8:20 A.M., Resident #60 was observed sitting in a wheelchair in front of the elevator by the nurses' station. There was a seat belt restraint in place. CNA #8 requested the resident to take the belt off. The buckle of the belt was next to the back of the seat on the right side and turned upside-down. The resident attempted several times to remove the belt. He stated "I can't do it." The buckle was moved to the center of the resident's lap and turned right side up. He was again requested to remove the belt. He attempted to remove it several times and repeated "I can't do it." Resident #60's clinical record was	F0221	**1. What action was taken to correct the deficient practice for affected residents? a) MD was notified on resident and care plan corrected and assessments updated 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All residents with self release seat belts will be immediately assessed to see that they can release the belts on command b) All nurses were in-serviced on pre-restraint assessments and the follow through of restraint paperwork 3. What measures or systemic changes were put into place to be sure this does not recur? a) A self release seat belt assessment area was added to each monthly summary, as well as a short narrative section at the bottom of the monthly summary record to be filled out if indicated. 4. How will corrective actions be monitored? a) The Nursing unit manager will check the documentation on the monthly summary record monthly to be sure the resident can still release the seat belt upon command and report results to QA 5. All changes will be in place by 2-15-12**	02/15/2012

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	reviewed on 1/10/12 at 1:15 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, chronic renal failure, obesity, and recurrent hypoxia. A Minimum Data Set annual assessment dated 11/14/11 indicated the resident was moderately impaired in cognitive decision-making skills, required limited assistance with locomotion on and off the unit, and had no restraints. A resident care plan dated 11/22/11 indicated "...Self release seatbelt with alarm to prevent unassisted transfers..." A physician's orders recapitulation dated January 2012 indicated "...Self releasing seat belt w/ (with) alarm, will undo at will and command..." A nurses' note dated 12/27/11 at 8:00 P.M. indicated " Res (resident) up in W/C (wheelchair). Stated wanted a pair of scissors to cut off seat belt..." Documentation was lacking in the clinical record to indicate a pre-restraining assessment or ongoing assessments had been completed for the resident's seat belt restraint. Interview on 1/10/12 at 1:55 P.M. with			

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	Unit Manager (UM) #5 indicated no assessment had been completed because "he can take it off." Review on 1/10/12 at 2:30 P.M. of a facility policy and procedure dated 6/98, provided by UM #5, identified a current, and titled "Restraint Use" indicated "...With the use of restraints the following must be completed:...Pre-restraint Assessments will be completed when a restraint is being considered, there is a change in the restraint, and up-dated quarterly..." 3.1-3(w)			

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F0252 SS=B	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure residents' environment was clean for 2 of 6 units in the facility (MacArthur 2, MacArthur 3). Findings include: 1. On 1/11/12 at 9:15 A.M., during an environmental tour with the Assistant Superintendent and the Maintenance Supervisor, the following were observed: A. MacArthur 2: 1. There was a brownish substance, identified as "urine", under the toilet in the south shower room. 2. There was a round metal piece missing from the temperature control in the shower in the north shower room. 3. There were brown and white stains on the seat of a blue sofa in the north lounge. B. MacArthur 3: 1. There were two foot splints stored under the sink in the south clean utility room. 2. There was a 2-inch by 3-inch scraped area and a 2-foot by 2-inch scraped area along the left wall in the south dining room. The plasterboard was visible. Interview on 1/11/12 at 10:40 A.M. with the	F0252	**1. What action was taken to correct the deficient practice for affected resident or area? a) Areas were immediately cleaned and repaired. Furniture was removed that appeared soiled. b) Splints were removed from area and returned to OT c) The round metal piece on the temperature control was replaced d) The 2x3 scraped area was patched and repainted on 01/13/2012 e) 2'x2" scraped area was also patched and repaired 2. How are other areas identified and what corrective action will be taken to prevent it from occurring? a) A walk through was done on each unit in all areas looking for soiled furniture, cracks in walls, etc. Anything in need of repair was done at that time. b) In-services were done on environmental protection and practices on all staff c) All other buildings will be inspected and work orders generated for repairs. 3. What measures or systemic changes will be put into place to assure this does not recur? a) It will be added to the night shift duty list for supervisors to make a walk through of each utility room to check that items are**	02/15/2012

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	Assistant Superintendent and the Maintenance Supervisor indicated they agreed with the above observations. 3.1-19(f)		**not under sinks and that furniture is in good appearance. b) A sign "Do not store under sink" has been posted. c) Items identified have been added to the housekeeping daily checklist to be cleaned. d) Maintenance will inspect monthly. 4. How will the corrective actions be monitored? a) The supervisor will do audits daily x 30 days, then monthly x 3 months then quarterly thereafter and report findings to maintenance and QA b) Housekeeping Supervisor will audit monthly. c) Maintenance will conduct a monthly preventive maintenance inspection. 5. Changes will be complete by 2-15-12**	

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). Based on observation, record review and interview, the facility failed to have an initial care plan for 1 of 24 residents reviewed for care plans. [Resident #159] Findings include: Record review for Resident #159 was completed on 1/9/12 at 2:11 P.M. Diagnoses included, but were not limited to, diabetes mellitus, history of falls, seizures and high blood pressure. Resident #159 was admitted 11/4/11 from the hospital, after a fall at home where he sustained lacerations and bruising to his head, forehead and face. The care plans were dated 11/16/11.	F0279	**1. What action was taken to correct the deficient practice for affected resident? a) MD and family notified 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All staff were in-serviced on locations of care plan books and policies and procedures of care plans upon admission and readmission3. What measures or systemic changes were not into place to be sure this does not re-occur? a) We have extended our policy to include that nurses will initiate at least 3 care plans upon each new admission 4. How will the corrective action**	02/15/2012

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	During observation on 1/10/12 at 10:20 A.M., Unit Manager #6 looked in the unit file cabinets because the resident was transferred from another floor. The Unit Manager was unable to locate the resident's admission care plan. Unit Manager #6 indicated in an interview on 1/10/12 at 10:20 A.M. she would look for the admission care plans. In an interview at the daily conference on 1/10/12 at 2:50 P.M. the Director of Nursing indicated they did not find any care plans prior to the date of 11/16/11. 3.1-35(a)		**be monitored? a) The Nursing unit manager will be responsible for checking each new admission chart within 48 hours of admission for initial care plans for each admission and report results to QA b) The unit manager will be responsible for checking each readmission chart for all updates and edits to care plans within 48 hours of readmission with each readmission and report results to QA 5. Changes will take place by 2-15-12**	

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F0282 SS=D	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 of record review and interview, the facility failed to follow hospital discharge orders for Omeprazole (an anti-ulcer medication). Resulting in the Resident receiving double the amount ordered by the discharging hospital physician. This impacted 1 of 24 residents reviewed for following physician's orders in a sample of 24. (Resident #160) Findings include: The clinical record of Resident #160 was reviewed on 1/10/12 at 10:45 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, dementia and GERD (gastric esophageal reflux disease). A hospital discharge order, dated 12/18/11, indicated "Omeprazole 20 mg (milligrams) po (by mouth) QD (everyday)." The order prior to hospitalization was for Omeprazole 2 mg/ml (milliliter) take 20 cc (cubic milliliter) po QD [Omeprazole 40 mg QD]. A Medication Administration Record (MAR), dated for December 18 - 31,	F0282	**1. What action was taken to correct the deficient practice for the affected resident? a) MD and family was notified of error 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All other orders for that medication were checked and no errors had occurred b) Staff was in-serviced on how to check admission orders 3. What measures or systemic changes were put into place to be sure this does not re-occur? a) Nuring unit manager will check all readmit orders from hospital readmits and from MD appts within 24 hours of readmit to assure orders are correct 4. How will corrective actions be monitored? a) All readmit charts and patients returning from MD appointments with orders will be audited for accuracy and results reported to QA for at least 3 months. b) After 3 months, we will review the accuracy reported to QA and determine how to proceed at that point, but will at least do a random sample of readmit charts monthly and report results to QA 5. Changes will be completed by 2-15-12**	02/15/2012

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	2011, indicated Omeprazole 20 mg po QD. A MAR, dated for the month of January 2012, indicated "Omeprazole 2 mg/ml take 20 cc by mouth once daily before breakfast. The Resident received this dosage five times, before the facility physician signed the order changing the Omeprazole from 20 mg a day to Omeprazole 2 mg/ml take 20 cc [40 mg a day] on 1/5/12. During an interview with RN #9, on 1/10/12 at 2:10 P.M., she indicated the discharge order from the hospital was for Omeprazole 20 mg po QD and the January MAR indicate the Resident had received Omeprazole 40 mg QD until the facility physician signed the new order on 1/5/12. 3.1-35(g)(2)			

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F0284 SS=D	When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on record review and interview, the facility failed to prepare discharge instructions for a resident upon discharge to home for 1 of 3 residents reviewed for discharge in a sample of 26. [Resident #171] Findings include: Record review for Resident #171 was completed on 1/12/12 at 12:15 P.M. Diagnoses included, but were not limited to, chronic pain, paraplegia, depression, anxiety, and history of urinary tract infections. A physician's order dated 12/22/11 indicated the resident could be discharged to home. A document titled, "Discharge/Furlough/Leave Instructions" dated 12/28/11, indicated under section titled, "...Current Medications with Instructions (must be listed in lay terms): See attached med sheets and treatment sheets..."	F0284	**1. What action was taken to correct the deficient practice for affected resident? a) MD was notified 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All units were contacted to verify with social workers those residents preparing for discharge. b) Nurses were in-serviced on proper discharge instructions and the importance of going over instructions in lay terms 3. What systemic changes were put into place to be sure this does not reoccur? a) A typed form will be attached to all discharge instructions that specifically state what all abbreviations stand for, such as po, qd, bid, tid, qid, and any other instructions that are on med sheets. b) Nursing unit manager will be responsible for double checking that all abbreviations on med sheets are on typed, attached sheet and patient, and or guardian will sign along with discharging nurse that they both agree and understand instructions 4. How will the**	02/15/2012

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	In an interview with the Director of Nursing (DON) on 1/12/12 at 3: 05 P.M., she provided documentation she indicated the forms she provided were the attached med and treatment sheets indicated on the discharge instruction sheet. The medication sheets were the MAR (medication administration record) sheets the nursing staff uses to pass medications to residents. The medications were written out in medical terms (QD, BID) and there were no laymen's terms (every day, twice a day) provided to indicate to resident what different terms mean. In an interview with the DON on 1/12/12 at 3:06 P.M., she indicated she understood the medications instructions were not in laymen's terms. 3.1-36(a)(3)		**corrective action be notified?** **a) Copies of each discharge will be made by the nurse and audited by Nursing unit manager for completeness of discharge instructions and signatures. All discharge audits will be reported to QA 5. Changes will be in place by 2-15-12**	

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F0309 SS=D	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 a pain assessment was completed prior to the administration of as needed pain medications for 2 of 13 residents with pain in a sample of 26. (Residents #60 and # 94). Findings include: 1. Resident #60's clinical record was reviewed on 1/10/12 at 1:15 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, right renal cyst, chronic renal failure, osteoporosis, and obesity. A physician orders recapitulation dated January 2012 indicated "...Acetaminophen (Tylenol) tab (tablet) 325 mg (milligrams). Take 2 tablets by mouth every 4 hours as needed for pain, headache, or temp. (temperature) (oral) > (greater than) 100.5" and "Hydrocodone/APAP 5/500 (a narcotic pain medication). Take 1 tablet by mouth every 4 hours as needed for pain..." Medication Administration Records	F0309	**1. What action was taken to correct the deficient practice for affected residents? a) MD and families notified 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All residents charts receiving prn pain medications were reviewed and pain assessments were updated b) All QMAs and nurses were in-serviced on pain assessments and the need for the nurse to assess prior to the qma giving the pain medication. 3. What measures or systemic changes were put into place so that this error does not reoccur? a) After residents request prn medication, nurse will assess resident and chart on back of MAR and cosign with QMA on MAR. b) Any significant changes with pain will be reported to the MD, family and MDS 4. How will corrective action be monitored? a) Nursing unit manager and supervisors will check med sheets daily for correct procedures x 30 days, monthly x 3 months, then quarterly**	02/15/2012

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	indicated: November, 2011 - the acetaminophen had not been given; the hydrocodone had been given 12 times. December, 2011 - the acetaminophen had not been given; the hydrocodone had been given 12 times. January 1-8, 2012 - the acetaminophen had not been given; the hydrocodone had been given 5 times. Documentation was lacking related to a pain assessment being completed to determine the level of pain prior to the administration of the hydrocodone. Interview on 1/10/12 at 1:55 P.M. with Unit Manager (UM) #5 indicated assessing the pain "is good nursing practice." She indicated pain assessments had not been done. 2. Resident #94's clinical record was reviewed on 1/11/12 at 1:30 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, C5 (5th vertebra of the cervical spine) burst fracture, spastic, post-traumatic stress syndrome and anxiety. A physician orders recapitulation dated January 2012 indicated "...Acetaminophen		**thereafter and report results to QA 5. Changes will take place by 2-15-12**	

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	(Tylenol) tab 325 mg. Take 2 tablets by mouth every 6 hours as needed for pain or temp" and "Hydrocodone/APAP 5/500. Take 2 tablets by mouth every 6 hours as needed for pain..." Medication Administration Records indicated: October, 2011 - the acetaminophen had not been given; the hydrocodone had been given 5 times. December, 2011 - the acetaminophen had not been given; the hydrocodone had been given 7 times. January 1-8, 2012 - the acetaminophen had not been given; the hydrocodone had been given 1 time. Documentation was lacking related to a pain assessment being completed to determine the level of pain prior to the administration of the hydrocodone. Interview on 1/10/12 at 1:55 P.M. with Unit Manager (UM) #5 indicated assessing the pain "is good nursing practice." She indicated pain assessments had not been done. A facility policy and procedure was requested of the UM #5 on 1/10/12 at 1:55 P.M. As of exit on 1/12/12 no policy and procedure was provided for review.			

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	3.1-37(a)			

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F0323 SS=E	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. A. Based on record review, interview, and observation, the facility failed to implement fall interventions for a resident identified as high fall risk with previous injury. The deficient practice included 1 of 12 resident's reviewed for falls in a sample of 26. [Resident #35] B. Based on record review, observation and interview, the facility failed to ensure the proper storage of chemicals in a community shower room. The deficient practice impacted 2 of 2 unlocked shower rooms. This deficient practice had the potential to affect 29 residents who were ambulatory or could self propel in a wheelchair. [Room 383 and Room 283] Findings include: A. On 1-10-12 at 9:35 A.M., Resident #35's record was reviewed. Diagnoses included, but were not limited to, dementia, depression, anxiety, osteoporosis, and status post left hip fracture on 8/6/11. Resident #35 was admitted to the facility on 8-11-11. A "Fall Risk Assessment" dated 8-11-11 indicated the score of 14 [high fall risk]	F0323	**1. What action was taken to correct the deficient practice for affected resident? a) MD and family notified b) Chemicals immediately locked up 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All charts were reviewed on residents at risk for falls b) Interventions were reviewed on care plans for completeness and accuracy and compared to kardexes c) Staff were in-serviced on falls and the possible interventions d) Nursing staff in-serviced on chemical storage policy e) All shower rooms checked for any chemicals out. None found 3. What measures or systemic changes will be put into place to be sure that this does not recur? a) All residents presenting with a fall will be reviewed by the interdisciplinary team within 24 hours to be sure they have a new intervention put into place with each fall b) The care plan will be updated with the new intervention at that time to reflect the new intervention c) All chemicals will be in a locked cabinet in shower**	02/15/2012

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	and dated of 11-18-11 indicated 20 [high fall risk]. A "Minimum Data Set" [MDS] screening assessment dated 8/17/11 indicated a "Brief Interview Mental Status" [BIMS] score of 10 [moderate cognitive impairment] and a MDS screening assessment dated 11/7/11 indicated a BIMS score of 9 [moderate cognitive impairment]. An MDS screening assessment dated 11/7/11 included, but was not limited to, "Transfer: 3/2 [extensive assistance with 1 person assistance]. On 1-11-12 at 8:30 A.M., the Director of Nursing provided a document titled "Timeline on [Resident #35]: Regarding falls and interventions." The following are dates and times of falls; 8-20-11 at 10:45 A.M., 9-16-11 at 4:47 P.M., 10-25-11 at 2:30 P.M., 1-2-12 at 6:45 P.M., and 1-7-12 at 10:30 A.M. The following "Resident Care Plan" included interventions added to Resident #35's plan of care on 8-18-11 after admission to the facility and status post left hip fracture on 8/6/11. A "Resident Care Plan" dated Run Date 8-18-11, Team Conference Date 8-18-11,		**rooms whether door to shower room in locked or not 4. How will the corrective action be monitored? a) The Nursing unit manager will perform audits on each fall weekly to be sure the care plan has been updated and will compare the interventions to be sure they are new. This will occur each week and results reported to QA b) Nursing unit manager will audit shower rooms daily x 30 days, monthly x 3 months, then quarterly thereafter and report results to QA 5. Changes will take place by 2-15-12**	

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	Start Date 8-18-11, included, but was not limited to, "Resident is at risk for falls d/t [due to] history of falls, weakness, pain, dementia, and takes psychotropic meds... Resident will be free from injury, Goal Date: 2/17/12... Approach with date of 8/18/11: Fall risk assessment quarterly and as needed, matts [mats] at each side of bed, bed and w/c [wheelchair] clip alarm to alert staff of unassisted transfers..., hi/lo bed, 1/2 siderails x 2 for bed mobility and positioning, call light in reach, encourage resident to ask for staff assistance for transfers, keep room free from clutter, refer to therapy as needed, staff to assist with all transfers..." The following Approach with date 9-21-11 was added after fall on 9-16-11: "PT [physical therapy] to evaluate for safety..." The "Timeline on [Resident #35]: Regarding falls and interventions included, but was not limited to, "9-22-11: [Physical Therapy] documented [Resident #35] was currently on caseload for gait training, balance, and transfer deficits..." Therefore, the above intervention was not a new intervention to prevent falls. The following Approach with date 10-25-11 was added after fall on			

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	10-25-11: Gripper socks and appropriate shoes and Approach with date 11-17-11: Educate on need for assist with transfers with each episode of unassisted transfer. However, the "Timeline on [Resident #35]: Regarding falls and interventions included the following written statement from the Director of Nursing, "Patient is somewhat limited to redirection due to cognitive abilities..." The following Approach with date 1-4-12 after fall on 1-4-12: Chair pad alarm. The "Timeline on [Resident #35]: There were no new interventions placed after the last documented fall on 1-7-12 at 10:30 A.M. On 1-12-12 at 10:00 A.M., an activities staff member walked by the nurse's station and indicated to Qualified Medication Assistant [QMA] #3 the resident was trying to get our of her wheelchair. At that time QMA #3 was observed walking to the residents room to assist. Upon entering, the resident was observed in wheelchair reaching for her recliner. At that time, the resident indicated she wanted in her chair and was trying to move the recliner closer to her. Call light was not in reach, wheelchair pad was on but not sounding. The resident was assisted to her recliner with assistance of 1 [QMA#3].			

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	On 1-12-12 at 11:30 A.M., the Director of Nursing indicated she did not know what else to do with Resident #35 and her interventions. She indicated the resident will take off her alarms and continues to get up without assistance. The Director of Nursing indicated her dementia appears to be getting worse. B. On 1-9-12 at 9:40 A.M., tour was initiated with Nursing Supervisor #4 and Nursing Supervisor #5. There were no residents who were identified as bed-fast. 29 residents were identified as ambulatory or able to self propel in a wheelchair. These residents were also identified as cognitively non-interviewable. On 1-11-12 at 9:15 A.M., environmental tour was initiated with the Physical Plant Director. At 10:15 A.M., 3 boxes of multi-pack "BD EZ Scrub 408 Surgical Scrub Brush/Sponge with Emollient and Nail Cleaner" were observed unsecured in Room 383, the community shower room. The label included, but was not limited to, "Keep Out of Reach of Children." At that time, the Physical Plant Director indicated the shower room was never locked and there was no lock on the door, the door is kept open.			

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	At 10:30 A.M., 1 open box of multi-pack "BD EZ Scrub 408 Surgical Scrub Brush/Sponge with Emollient and Nail Cleaner" was observed unsecured in the community shower, Room 283. At that time, the Physical Plant Director indicated the door does not have a lock and is kept open at all times. On 1-11-12 at 12:30 P.M., the Director of Nursing provided a copy of a document titled, "Policy/Procedure: Chemical Solutions For Cleaning." The policy included, but was not limited to, "Policy: all chemicals used on nursing home units will be kept in a locked cabinet at all times... all chemicals used will be kept in a locked cabinet (in the shower room...) on each nursing home unit..." 3.1-45(a)(2) 3.1-45(a)(1)			

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, observation and interview, the facility failed to ensure the Pharmacy reconciled a medication ordered on the hospital discharge orders and printed the incorrect amount of Omeprazole (an anti-ulcer medication) on the Medication Administration Record and Physicians' summary for the month of January 2012. This resulted in the facility giving the incorrect dose of medication and resulting in the Resident receiving the wrong dose of medication for 5 days. This impacted 1 of 24 residents reviewed for medication discrepancies in a sample of 24. (Resident #160) Findings include:	F0425	**1. What action was taken to correct the deficient practice for affected resident? a) MD and family notifiedb) Pharmacy will have designated staff for entering orders and reviewing readmits. Currently all pharmacy staff complete this step. Now, an individual technician will be assigned to this task only. This should help improve the efficacy as well as efficiency in this area.** **2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All residents with orders for this medication were checked for error and had no medication**	02/15/2012

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	The clinical record of Resident #160 was reviewed on 1/10/12 at 10:45 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, dementia and GERD (gastric esophageal reflux disease). A hospital discharge order, dated 12/18/11, indicated "Omeprazole 20 mg (milligrams) po (by mouth) QD (everyday)." The order prior to hospitalization was for Omeprazole 2 mg/ml (milliliter) take 20 cc (cubic milliliter) po QD [Omeprazole 40 mg QD]. A Medication Administration Record (MAR) hand written by nursing, after the Resident's return from the hospital, dated for December 18 - 31, 2011, indicated Omeprazole 20 mg po QD. A MAR printed by the Pharmacy, dated for the month of January 2012, indicated "Omeprazole 2 mg/ml take 20 cc by mouth once daily before breakfast. The facility physician signed the order changing the Omeprazole from 20 mg a day to Omeprazole 2 mg/ml take 20 cc [40 mg a day] on 1/5/12. During an observation, on 1/10/12 at 1:50 P.M., a 250 ml bottle of Omeprazole,		**error b) All nurses were in-serviced on correct policies and procedures of readmission orders c) We will QA the process on a monthly basis to ensure that this does not happen again3. What measures or systemic changes were put into place to be sure this does not recur? a) Nuring unit managers will check all readmission orders from hospital or MD appts to verify accuracy**b) **See attached form. Will be reported in QA. 4. How will corrective actions be monitored? a) Nursing unit managers will audit readmit orders with each readmission or MD appt and report results to QA**b) We are in the process of training everyone on the new procedure. We have started to implement. Once we are done with cart fill we will rearrange the pharmacy to make it more useable for the new process. The entire process will be in full force starting Feb 13 with the start of the new contract. **5. Changes will be in place by 2-15-12**	

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	labeled Omeprazole 2 mg/ml take 20 cc by mouth once daily before breakfast, was in the unit medication refrigerator. The date for the order, on the bottle, was 10/7/10. During an interview with RN #9, on 1/10/12 at 2:10 P.M., she indicated the discharge order from the hospital was for Omeprazole 20 mg po QD and the Pharmacy's copy of the order was sent to the Pharmacy. The Pharmacy was called by unit staff, on 10/12/12/at 2:05 P.M. and was told the MAR and Physician's order sheet are correct because the Physician signed the Physicians' order sheet 1/5/12. 3.1-25(a)			

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F0465 SS=E	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 ensure the environment was functional and sanitary for residents for 1 of 6 units in the building. (Pyle 3). Findings include: 1. On 1/11/12 at 9:15 A.M., during an environmental tour with the Assistant Superintendent and the Maintenance Supervisor, the following were observed: A. Pyle 3: 1. There was a feeding pump sitting in the sink in the clean utility room. Interview at the time of the observation with the unit manager indicated the pump had been used on a resident and was not clean. 2. There was a red plastic biohazard bag sitting on the floor in the soiled utility room. The bag was open. 3. There were two black plastic bags containing washbasins and urinals stored under the sink in the soiled utility room. Interview at the time of the observation with UM #5 indicated she was unsure if the items were soiled or clean but they	F0465	**1. What action was taken to correct the deficient practice? a) Items were immediately corrected and maintenance director and Nursing unit manager were notifiedb)** The door was adjusted so the closure could shut the door completely **2. How were other items identified and what corrective actions will be taken to prevent it from occurring again? a) All units were audited for environmental and safety issues and corrected for any problems noted. b) Staff was in-serviced on infection control policies for biohazard containers, clean and soiled utility rooms and standard environmental issues c)** All the doors were inspected and made sure they closed all the way **3. What measures or systemic changes were put into place to be sure this does not reoccur? a) It will be added to the duties of the night supervisor to check all clean and soiled utility rooms to be sure all biohazard bags have been removed and that nothing is under sinks and all items are stored properly b)** A Preventive Maintenance schedule will be put in place to monitor that the doors shuts completely **4. How will**	02/15/2012

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	should not be stored under the sink. 4. The door to the stairwell was not completely closed. The door was a self closing and self locking door. The door was not adjusted properly to allow the magnet to engage to lock the door. There were no residents in the vicinity at the time of the observation. Interview with the Maintenance Supervisor indicated the door should close completely and he would fix it immediately. Interview on 1/11/12 at 10:40 A.M. with the Assistant Superintendent and the Maintenance Supervisor confirmed the above observations. 3.1-19(f)		**corrective actions be monitored? a) Supervisor will audit daily x 30 days, monthly x 3 months, then quarterly thereafter and report findings to QA b)** Audits will be completed by maintenance weekly for 60 days, then review in Quality Assurance, then do monthly for 90 days and quarterly after to be reviewed by Quality Assurance **5. All changes will take place by 2-15-12**	

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F0514 SS=D	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. 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. Based on record review and interview, the facility failed to have complete and accurate documentation for do not resuscitate orders, fluid restriction charting, admission orders pertaining to potassium, and authorization for QMAs to administer as needed medications for 6 out of 26 residents reviewed for documentation. [Resident #20, #60, #93, #94, #125, #160] [QMAs #11, #12, #13]. Findings include: 1. Record review for Resident #20 was completed on 1/10/12 at 11 A.M. diagnoses included, but were not limited to, CHF (congestive heart failure), atrial fibrillation, pacemaker, and dementia. Resident #20 was admitted on 8/2/11. The latest physician order dated 12/22/11 when the resident returned from hospital, indicated the resident is to be a do not resuscitate. The chart had a DNR (do not	F0514	**1. What action was taken to correct the deficient practice for the affected residents? a) MD and families notified. All errors corrected immediately and care plans updated as well as Kardexes 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All charts facility wide were checked for appropriate code status orders and corrected if wrong b) All residents with fluid restriction orders were added to the MAR and intake logs c) All residents on omeperazole were verified through pharmacy to be sure correct dosage was received d) Pain assessments were updated on all residents facility wide e) Nurses were in-serviced on pain assessments and the scope of practice for QMAsf) QMAs were in-serviced on the scope of practice and the need for a cosignature with a nurse after**	02/15/2012

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	resuscitate) sticker on the inside of front cover of chart. The MAR (Medication Administration Record) the place where nurses document medications they give to resident, the physician rewrites, for January 2012, both indicated the resident is a full code. In an interview with Unit Manager #6 on 1/10/12 at 11:10 A.M. she indicated the staff are to look inside chart for sticker as well as for orders in a code situation to see current status for residents. She looked at January physician rewrites and MAR and indicated they were not correct. 2. Record review for Resident #125 was completed on 1/12/12 at 8:30 A.M. Diagnoses included, but were not limited to, renal failure, diabetes mellitus, and dementia. Resident # 125 was admitted 12/29/11. The resident was currently receiving hemodialysis (a process to eliminate toxins from the body). A physician's order dated 1/3/12 indicated Resident #125 was to be put on a 1500 ml (milliliter) per 24 hour fluid restriction. A physician's order dated 1/5/12 indicated resident was to receive Nepro protein supplement.		**an assessment is done by a nurse g) In-servicing was done for nurses on code status papers, fluid restrictions and documentation, and readmit orders. 3. What measures or systemic changes were put into place to be sure this does not reoccur? a) Nurses will assess each resident prior to QMA administering prn meds and will document assessment on back of Mar and cosign with QMA. b) All readmit orders will be doublechecked by Nursing unit manager within 24 hours of readmit or new admit c) All new admit or readmit charts will be audited by Nursing unit manager to verify presence of code status orders 4. How will corrective actions be monitored? a) All above items will be audited by Nursing unit manager daily for 30 days, then monthly for 3 months then quarterly thereafter. b) All admission audits will be done with each admission 5. Changes will be completed by 2-15-12**	

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	An undated document located in the facility's Certified Nurse Aide manual for dietary documentation included the breakdown of the 1500 ml fluid restriction consumed throughout the day. The breakdown was as follows: Breakfast: milk -240 ml , cranberry juice-120 ml. Lunch: fruit punch- 240 ml. Supper: fruit punch-240 ml. HS (bed time) Nepro-180 ml. Med passes (4) water 120 ml. The January MAR indicated the resident was to receive the Nepro supplement (240 ml) at 2000 (8:00 P.M.) every day. The MAR did not indicate the amount of Nepro that was consumed every day. A document titled "Meal and Fluids Intake Log" for January 2012 indicated the fluids consumed so far this month. For the dates the fluid restriction was in place the following fluids were consumed: 1/3/12: LOA (leave of absence) 1/4/12: AM med pass- 120 ml. Lunch- 80/240 ml. Dinner: 60/240 ml. 1/5/12: Breakfast: 75/360 ml , Lunch: 75/240 ml. Dinner: 20/360 ml. PM med pass 120 ml. 1/6/12: LOA 1/7/12: LOA 1/8/12: AM and Mid morning med pass 120 ml each. Lunch: 100/240 ml.			

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	Afternoon med pass 120 ml, Dinner: 80/360 ml and PM med pass 120 ml. 1/9/12: Breakfast: 75/360 ml, Lunch: 75/360 ml, Dinner: 80/360 and PM med pass 120 ml. 1/10/12: Dinner 0/240 ml, and PM med pass 120 ml. In an interview with Unit Manager #6 on 1/12/12 at 9 A.M. she indicated the Nepro protein supplement was to be tracked regarding consumption on the Meal and Fluid Intake Log. She indicated she did not see the supplement being tracked on the form. 3. The clinical record of Resident #160 was reviewed on 1/10/12 at 10:45 A.M. Diagnoses included, but were not limited to, diabetes, high blood pressure, dementia and GERD (gastric esophageal reflux disease). A hospital discharge order, dated 12/18/11, indicated "Omeprazole (an anti-ulcer medication) 20 mg (milligrams) po (by mouth) QD (everyday)." A Medication Administration Record (MAR) hand written by nursing, after the Resident's return from the hospital, dated for December 18 - 31, 2011, indicated Omeprazole 20 mg po QD.			

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	A Pharmacy printed MAR and Physician's order sheet, dated for the month of January 2012, indicated Omeprazole 2 mg/ml take 20 cc [40 mg] by mouth once daily before breakfast, the order date was 10/7/10. The MAR and Physician's order sheet was not changed to the hospital discharge order, dated 12/18/11, of Omeprazole 20 mg a day. During an interview with RN #9, on 1/10/12 at 2:10 P.M., she indicated the discharge order from the hospital, dated 12/18/11, was for Omeprazole 20 mg po QD and the January 2012 MAR and Physician's order sheet, printed by the facility's Pharmacy, dated for January 2012, indicated Omeprazole 2 mg/ml take 20 cc by mouth once daily before breakfast [40 mg]. 4. The clinical record for Resident #93 was reviewed on 1/10/12 at 1:25 P.M. Diagnoses included, but were not limited to, chronic back pain, neurogenic pain, senile dementia--Alzheimer's type, and chronic obstructive pulmonary disease with pulmonary fibrosis. The January 2012 physician's order recap [recapitulation] list included, but was not limited to, the following medications: (5/2/08) Hydrocodone/APAP [a pain			

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	medication] 5/500 one tablet every 6 hours P.R.N.; (7/7/10) Lorazepam [an antianxiety medication] 0.5 mg. [milligrams] one every 4 hours P.R.N. for anxiety; and (10/14/08) Acetaminophen [Tylenol] 325 mg. two tablets every 4 hours P.R.N. pain/temperature. The reverse side of the December, 2011 and January, 2010 M.A.R.s indicated Q.M.A. #10 had given a P.R.N. dose of Lorazepam on 12/2/11 at 5:00 P.M.; P.R.N. doses of Lorazepam and Acetaminophen on 12/25/11 at 6:00 P.M.; and P.R.N. doses of Lorazepam and Acetaminophen on 1/10/12 at 1:30 P.M. There was no documentation on the M.A.R. or in the "Nursing Notes" that prior authorization from a licensed nurse had been obtained to administer the P.R.N. medications that were given, and there were no initials from a licensed nurse as a co-signature. The reverse side of the December, 2011 M.A.R. indicated Q.M.A. #11 had given a P.R.N. dose of Hydrocodone/APAP on 12/16/11 at 2:40 P.M.; and a P.R.N. dose of Acetaminophen on 12/21/11 at 4:00 P.M. There was documentation that authorization to administer the medication had been given by an L.P.N.; however, there were no initials from the authorizing			

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	nurse as a co-signature. The reverse side of the December, 2011 and January, 2012 M.A.R.s indicated Q.M.A. #12 had given P.R.N. doses of Hydrocodone/APAP and Lorazepam on 12/29/11 at 9:30 P.M.; P.R.N. doses of Hydrocodone/APAP and Lorazepam on 1/1/12 at 9:30 P.M.; and P.R.N. doses of Hydrocodone/APAP and Lorazepam on 1/6/12 at 9:00 P.M. There was no documentation on the M.A.R. or in the "Nursing Notes" that prior authorization from a licensed nurse had been obtained to administer the P.R.N. medications that were given, and there were no initials from a licensed nurse as a co-signature. In an interview on 1/12/12 at 3:25 P.M., the Director of Nursing indicated Q.M.A.s always obtained prior authorization before administering P.R.N. medications. She had not been aware, however, that the authorization needed to be documented, or that the licensed nurse was required to cosign. 5. Resident #60's clinical record was reviewed on 1/10/12 at 1:15 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, right renal cyst, chronic			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	renal failure, osteoporosis, and obesity. A physician orders recapitulation dated January 2012 indicated "...Acetaminophen (Tylenol) tab (tablet) 325 mg (milligrams). Take 2 tablets by mouth every 4 hours as needed for pain, headache, or temp. (temperature) (oral) > (greater than) 100.5" and "Hydrocodone/APAP 5/500 (a narcotic pain medication). Take 1 tablet by mouth every 4 hours as needed for pain..." Medication Administration Records dated November 2011 indicated the hydrocodone had been given 5 times by a QMAs #12 and #13. Documentation was lacking related to the resident having been assessed by a licensed nurse or the pain medication having been authorized by a licensed nurse prior to administration by the QMA. Interview on 1/11/12 at 2:07 P.M. with Unit Manager (UM) #5 indicated QMAs should get authorization from a licensed nurse prior to administering as needed pain medications. She indicated it should be documented on the Medication Administration Record. 6. Resident #94's clinical record was reviewed on 1/11/12 at 1:30 P.M. The record indicated the resident was admitted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	01/12/2012

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	with diagnoses which included, but were not limited to, C5 burst fracture, spastic, post-traumatic stress syndrome and anxiety. A physician orders recapitulation dated January 2012 indicated "...Acetaminophen (Tylenol) tab 325 mg. Take 2 tablets by mouth every 6 hours as needed for pain or temp" and "Hydrocodone/APAP 5/500. Take 2 tablets by mouth every 6 hours as needed for pain..." Medication Administration Records dated October 2011 indicated the hydrocodone had been given 1 time by a QMA #13. Documentation was lacking related to the pain medication having been authorized by a licensed nurse prior to administration by the QMA. Interview on 1/11/12 at 2:07 P.M. with Unit Manager (UM) #5 indicated QMAs should get authorization from a licensed nurse prior to administering as needed pain medications. She indicated it should be documented on the Medication Administration Record. 3.1-50(a)(1) 3.1-50(a)(2)			

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F0516 SS=D	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on record review, observation and interview, the facility failed to maintain confidentiality of resident records by leaving resident records unsecured in a nurse unit manager's office that was open and easily accessible to unauthorized individuals. The deficient practice impacted 1 of 1 unlocked nurse unit manager offices. [Room 380] Findings include: On 1-11-12 at 9:15 A.M., environmental tour was initiated with the Physical Plant Director. At 9:35 A.M., room 380, the unit nurse manager's office, was observed open. Upon entering, unsecured resident records were observed on the unit manager's desk and located around the room. No one was in the office. The office was located by the main elevator and across from the	F0516	**1. What action was taken to correct the deficient practice for affected residents? a) The possible breach was reported to the HIPAA compliance officer. 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All other office doors were checked and secured. b) All staff facility wide were in-serviced on HIPAA policies 3. What measures or systemic changes were put into place to be sure this does not reoccur? a) Security will report any open doors to offices that are not occupied directly to the director in charge of that department as well as the HIPAA compliance officer 4. How will corrective actions be monitored? a) Nursing unit managers will audit each others units weekly x 3 months, then quarterly and report to QA b) ADONs will**	02/15/2012

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	nurse's station. At 9:50 A.M., room 380 was observed open. At that time, a staff member walked in the room and upon exit did not close the door. Records were observed unsecured as before. The Physical Plant Director instructed the staff member to return to close the door and made certain the door was locked. In an interview on 1-11-12 at 10:50 A.M., the Administrator indicated all resident records were to remain secure. On 1-11-12 at 12:30 P.M., the Director of Nursing provided a document titled, "HIPAA [Health Insurance Portability and Accountability Act of 1996] Safeguarding and Storing PHI [Protected Health Information] Policy" dated 9-1-08. The policy included, but was not limited to, "Active Records on Nursing Units: shall not be left unattended on the nurses' station desk or other areas where residents, visitors and unauthorized individuals could easily view the records..." 3.1-50(d)		**audit each unit daily x 30 days, monthly x 3 months, then quarterly thereafter and report to QA c) Results of security rounds will be sent to QA 5. Changes will be complete by 2-15-12**	