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

PRINTED: 04/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445382		04/10/2013

NAME OF PROVIDER OR SUPPLIER: PIGEON FORGE CARE & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 415 COLE DRIVE, PIGEON FORGE, TN 37863

(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 282 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to follow the resident's written plan of care to prevent falls for one resident (#9), and failed to follow residents' written plan of care for behavior monitoring for three residents (#9, #17, and #150) of thirty-nine residents reviewed. The findings included: Resident #9 was admitted to the facility on July 1, 2011, with diagnoses including Osteoarthritis, Degenerative Joint Disease, Hypothyroid, Chronic Bronchitis, Hypertension, Coronary Artery Disease, History of Falls, and Depression. Medical record review of the Quarterly Minimum Data Set (MDS) dated December 18, 2012, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs). Medical record review of the resident's care plan dated September 25, 2012, revealed, "...at risk for fall related injury..." Continued review of the resident's care plan revealed, "...Approach 9/25/12...Assess for appropriate footwear; gripper socks or nonskid shoes ...nonskid socks when in	F 282	F282 What corrective action will be accomplished for residents found to be affected by deficient practice? Resident # 9, #17, and #150 had their care plans reviewed for accuracy and it was determined that the care plans for these residents were appropriate. Further review of an incident report for resident #9, revealed that the gripper socks were in the bed with her, but that she had likely taken them off on her own and unplugged the alarm on her own. The care plans have since been updated to reflect the potential that this resident may remove the gripper socks on her own at times. Also updated to reflect that she may remove alarm as well. Resident #17 now has a flow sheet in place to document mood and behaviors that this resident may experience. Resident #150 also now has a flow sheet in place with the MAR to document possible mood and behavior changes.	5/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4-25-13

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.

May. 15. 2013 2:25PM No. 5996 P. 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 1 bed...ensure gripper socks on at hs (hour of sleep)..." Further review of the resident's care plan revealed, "... 8/15/12 pressure pad alarm at hs at all x's (times)...2/25/13 ensure bed alarm in proper position..." Review of the facility investigation revealed the resident had a fall on February 25, 2013, with no injury. Continued review of the facility investigation revealed, "...bed alarm not sounding..." and "...slipped on socks..." Review of facility documentation revealed the resident had a fall on March 28, 2013, at 5:20 a.m. Continued review of facility documentation revealed the resident was "...up without shoes/socks with skid proof bottoms...bed alarm unplugged..." Interview with the Director of Nursing (DON) on April 10, 2013, at 9:45 a.m., in the Conference room, confirmed the resident's bed alarm was not sounding, and the resident was not wearing gripper socks at the time of the resident's fall on February 25, 2013. Continued interview with the DON, at that time, confirmed the resident's bed alarm was unplugged and the resident was not wearing gripper socks at the time of the resident's fall on March 28, 2013. Further interview with the DON, at that time, confirmed the facility did not follow the resident's plan of care for fall prevention. Medical record review of the resident (#9) Care Plan, dated September 25, 2012, revealed, "...Resident is at risk for changes in mood r/t (related to) dx (diagnosis) of depression..." Continued review of the resident's care plan	F 282	How will identify other residents having potential to be affected by same deficient practice Residents that are care planned for mood/behavior monitoring have been evaluated during the monthly review process/MAR change-over to determine and ensure that the necessary mood/behavior monitoring flow sheets are in place. Also, care plans for all residents with fall precautions noted have been reviewed to ensure that residents who may remove certain items on their own are identified appropriately and other recommendations made as necessary. These reviews have been accomplished by nursing Administration staff (MDS nurses, DON, ADON's, Staff Development Coord). What measures put into place or what systemic changes will you make to ensure deficient practice doesn't recur? Education of nursing staff (licensed and C.N.A's) related to compliance with care plan interventions is to occur by compliance date noted on this POC. Education will include reminders about residents with fall precautions and alarms and similar interventions. Education with licensed staff will include that they are able to make adjustments and revisions to care plans as necessary per resident needs.	5/10/13

Apr. 26. 2013 11:45AM No. 5269 P. 5

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F 282	Continued From page 2 revealed, "...Approach...monitor mood/behaviors per tracking tool..." Medical record review of the Medication Administration Record (MAR) for the month of April 2013, revealed no flow sheet for the documentation of mood or behaviors. Interview with the Director of Nursing (DON) on April 10, 2013, at 9:45 a.m., in the Conference room, revealed the facility utilized a flow sheet located with the resident's MARs to document the resident's moods and behaviors. Continued interview with the DON, at that time, revealed the absence of a behavior monitoring flow sheet for the month of April, 2013, and confirmed the facility did not follow the resident's plan of care for behavior monitoring. Resident #17 was admitted to the facility on February 28, 2013, with diagnoses including Hypertension, Osteoporosis, Hypothyroid, Cerebrovascular Accident, Dementia, and Depression. Medical record review of the Care Plan, dated March 19, 2013, revealed, "...Resident is at risk for changes in mood r/t (related to) dx (diagnosis) of depression,.." Continued review of the Care Plan revealed, "...Approach...monitor mood/behaviors per tracking tool..." Medical record review of the MAR for the month of April, 2013, revealed flow sheets for pain, oxygen therapy; and nebulizer treatments. Continued review of the resident's MAR revealed no flow sheet for the documentation of mood or	F 282	Education to licensed nursing staff will also note that any resident who requires behavior monitoring or may have mood changes must have a behavior monitoring flow sheet with the MAR for the nurse to complete as necessary. The Staff Development coordinator will complete this education. How will corrective action be monitored? A full audit of residents who need behavior monitoring flow sheets has been conducted and all appropriate flow sheets are in place. An audit of residents with interventions related to fall precautions has been conducted by nursing Administration staff (MDS, SDC, DON, ADONs) to ensure that listed interventions are appropriate. The weekly At-risk committee (Dietary mgr, MDS, ADONs, DON, Social Services) will review falls and incident reports from that week to determine that appropriate interventions are in place. The performance improvement committee (Administrator, DON, ADON's, SSD, Dietary Mgr, Maint Director, Env Services Director, Medical Director, Business Office Manager, HR Director, Chaplain, and Admissions Director) will review audits of fall precaution interventions and behavior monitoring sheets on a monthly basis for at least 3 months and then committee will make further recommendation as to continued need for additional review as necessary.	5/10/13

Apr. 26. 2013 11:46AM No. 5269 P. 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 3 behaviors. Interview with the DON on April 10, 2013, at 9:45 a.m., in the Conference room, revealed the facility utilized a flow sheet located with the resident's MARs to document resident's moods and behaviors. Continued interview with the DON revealed the absence of a behavior monitoring flow sheet for the month of April 2013, and confirmed the facility did not follow the resident's plan of care for behavior monitoring. Resident #150 was admitted to the facility on November 23, 2012, and readmitted to the facility on February 7, 2013, with diagnoses including Hypertension, Hypokalemia, Hyperlipidemia, Hypothyroid, Anemia, and Depression. Medical record review of the resident's Care Plan dated February 26, 2013, revealed, "...Resident is at risk for changes in mood and behaviors R/T (related to) dx (diagnosis) of depression..." Continued review of the care plan revealed, "...Approach...monitor mood/behaviors per tracking tool..." Medical record review of the resident's MAR for the month of April 2013, revealed no flow sheet for the documentation of the resident's mood or behaviors. Interview with the DON on April 10, 2013, at 1:13 p.m., in the Conference room, revealed the facility utilized a flow sheet located with the resident's MARs to document the resident's moods and behaviors. Continued interview with the DON, at that time, revealed the absence of behavior	F 282		

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F 282	Continued From page 4 monitoring flow sheet for the month of April 2013, and confirmed the facility did not follow the resident's plan of care for behavior monitoring.	F315	What corrective action will be accomplished for residents found to be affected by deficient practice? Resident #177 was evaluated for B + B on 4-24-13 and was placed on a bowel and bladder program. How will identify other residents having potential to be affected by same deficient practice? All residents who are found to be incontinent of bowel and bladder would have potential to be at risk if appropriate assessments are not completed. New admissions, if found to be incontinent of B + B, and deemed appropriate for training, will be assessed and placed on the bowel and bladder training program. Reviewed residents in-house at the time of POC submission, and plans in place at that time found to be appropriate What measures put into place or what systemic changes will you make to ensure deficient practice doesn't recur? Education of licensed nursing staff will be conducted to ensure that licensed nursing staff are aware of requirement to assess new admissions or any current resident who may experience a significant change in this area of their health. Any residents found to be in need of a B + B training program will be added to the program and monitored appropriately. Staff Development Coordinator will complete this education.	5/10/13
F 315 SS=D	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 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to complete a bladder assessment and develop an individualized toileting plan for one resident (#177) of thirty-nine residents reviewed. The findings included: Resident #177 was admitted to the facility on March 29, 2013, with diagnoses including Aftercare Traumatic Fracture Hip, Depressive Disorder, Hypertension, Anemia, and History of Fall. Medical record review of a System Evaluation note completed on admit on March 29, 2013, revealed the resident was incontinent of bowel and bladder.			

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F 315	Continued From page 5	F 315		
	Review of facility policy, Bowel and Bladder Incontinence Management, revealed "...Procedure: 1. Newly admitted incontinent residents...will initiate appropriate interventions and place the resident on the restorative care plan..."		How will corrective action be monitored? 5/10/13	
	Interview with the Director of Nursing (DON) and the 100 hall unit manager on April 10, 2013, at 8:10 a.m., in the DON office, revealed the resident had not been evaluated for bowel and bladder incontinence and had been identified as having some incontinence episodes. Continued interview confirmed the facility had failed to assess the resident for a bowel and bladder program, and an individualized toileting program had not been developed.		Medical Records Supervisor (LPN) will monitor the new admissions on a weekly basis for compliance with the Bowel and Bladder assessments. MDS staff will ensure that any resident experiencing a significant change has the appropriate assessments and training programs in place. The results of these reviews/audits will be shared at the monthly Performance Improvement committee (Administrator, DON, ADON's, SSD, Dietary Mgr, Maint Director, Env Services, Director, Medical Director, Business Office Manager, HR Director, Chaplain, and Admissions Director) meetings each month for a minimum of 3 months and then re-evaluated for continued need for additional audits.	
F 323 SS=D	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.	F323	What corrective action will be accomplished for residents found to be affected by deficient practice? 5/10/13	
	This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to ensure safety devices were in place and functioning to prevent falls for one resident (#9) of thirty-nine residents reviewed.		Resident #9 was evaluated for safety devices that they were in proper working order and in proper position for this resident. This was accomplished on April 10, 2013. Further review of an incident report for resident #9, revealed that the gripper socks were in the bed with her, but that she had likely taken them off on her own and unplugged the alarm on her own. The care plans have since been updated to reflect the potential that this resident may remove the gripper socks and the alarm on her own at times.	

May. 15. 2013 2:25PM No. 5996 P. 4

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F 323	Continued From page 6 The findings included: Resident #9 was admitted to the facility on July 1, 2011, with diagnoses including Osteoarthritis, Degenerative Joint Disease, Hypothyroid, Chronic Bronchitis, Hypertension, Coronary Artery Disease, History of Falls, and Depression. Medical record review of the Quarterly Minimum Data Set (MDS) dated December 18, 2012, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs). Medical record review of the Care Plan dated September 25, 2012, revealed, "...at risk for fall related injury..." Continued review of the Care Plan revealed "...Assess for appropriate footwear; gripper socks or nonskid shoes...nonskid socks when in bed..." Further review of the Care Plan revealed "...pressure pad alarm at hs (hour of sleep) at all x's (times)..." Review of facility investigation revealed the resident had a fall on February 25, 2013, with no injury. Continued review of facility investigation revealed, "...bed alarm not sounding...slipped on socks..." Further review of the facility investigation dated February 25, 2013, revealed"...repositioned bed alarm...assure (ensure) in correct alignment with resident...staff ed (education)...gripper socks..." Review of facility investigationtation revealed the resident had a fall on March 28, 2013, at 5:20 a.m., with no injury. Continued review of the facility investigation revealed the resident was "...up without shoes/socks with skid proof	F 323	How will identify other residents having potential to be affected by same deficient practice? Residents with safety devices/footwear/interventions for fall precautions have been reviewed by nursing administration staff (ADON's, SDC) to determine that all appropriate devices are functioning and that those interventions listed are still appropriate for those residents' needs. Other residents with fall precautions noted have potential to be affected if devices aren't in place or aren't functioning. What measures put into place or what systemic changes will you make to ensure deficient practice doesn't recur? Education of nursing staff (licensed and C.N.A's) related to compliance with care plan interventions is to occur by compliance date noted on this POC. Education will include reminders about residents with fall precautions and alarms and similar interventions. Education with licensed staff will include that they are able to make adjustments and revisions to care plans as necessary per resident needs. Staff Development coordinator will complete this education. How will corrective action be monitored? The weekly At-risk committee (Dietary mgr, MDS, ADONs, DON, Social Services) will review falls and incident reports from that week to determine that appropriate interventions are in place. The performance improvement committee (Administrator, DON, ADON's, SSD, Dietary Mgr, Maint Director, Env Services	5/10/13

May. 15. 2013 2:26PM No. 5996 P. 5

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F 323	Continued From page 7 bottoms...bed alarm unplugged..." Interview with the Director of Nursing (DON) on April 10, 2013, at 9:45 a.m., in the Conference room, confirmed the resident was not wearing gripper socks and the bed alarm was not sounding at the time of the resident's fall on February 25, 2013. Continued interview with the DON confirmed the resident was not wearing gripper socks, and the bed alarm was unplugged at the time of the resident's fall on March 28, 2013. Continued interview with the DON confirmed the facility failed to ensure safety devices were in place to prevent falls.	F 323	Director, Medical Director, Business Office Manager, HR Director, Chaplain, and Admissions Director) will review audits of fall precaution interventions on a monthly basis for at least 3 months and then committee will make further recommendation as to continued need for additional review as necessary.	5/10/13
F 329 SS=D	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 residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 What corrective action will be accomplished for residents found to be affected by deficient practice? Resident #5's medication regimen was reviewed during state survey and the med was discontinued as of April 10, 2013. Resident #5 evaluated by physician on April 25, 2013, and it was determined by doctor that the resident had no residual issues from receiving the medication longer than what it was ordered.	5/10/13

Apr. 30. 2013 10:19AM No. 5361 P. 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 8	F 329		
	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to discontinue an unnecessary medication for one resident (#5) of ten residents reviewed. The findings included: Resident #5 was admitted to the facility on February 12, 2013, with diagnoses including Prostate Cancer, Osteomyelitis, Diabetes Mellitus II, Bipolar Disorder, Insomnia, and Adjustment Disorder. Medical record review of the Physician's Orders on admission dated February 12, 2013, revealed the resident was to receive Hydroxyzine (used for anxiety and sedation) 25 milligrams (mg) at bedtime. Medical record review of the Physician's orders dated February 13, 2013, revealed, "...Stop Hydroxyzine..." Medical record review of the Medication Administration Record (MAR) for February 2013, revealed the resident received the Hydroxyzine February 12th and 13th, and written on the record after February 13th was, "dc (discontinue) 02/13/13." Medical record review of the MAR for March		How will identify other residents having potential to be affected by same deficient practice? Facility is conducting audit of currently ordered medications as part of the monthly change-over process for the MARs going from April to May 2013. Licensed nursing staff who are conducting this changeover/audit will ensure that the residents only have medications present that are accompanied by the appropriate physician's order. All residents have potential to be affected if a medication isn't discontinued in a timely manner per the physician's directives. What measures put into place or what systemic changes will you make to ensure deficient practice doesn't recur? Education has been delivered by Staff Development Coordinator to licensed nursing staff related to the proper discontinuation of medication per physician's orders. This education includes a review of the appropriate policy related to medication commencement and discontinuation.	5/10/13

Apr. 30. 2013 10:19AM No. 5361 P. 5

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F 329	Continued From page 9 2013, revealed, "Hydroxyzine...25mg...orally at bedtime. Dx (diagnosis): Anxiety." Further review of the MAR revealed the resident received the Hydroxyzine every day except March 1-4, 22nd, 26th, and 30th. Medical record review of the MAR for April 2013, revealed the Hydroxyzine was on the MAR to be administered to the resident and was given on the 2nd, 3rd, and 7th. Further review of the record revealed, after the 7th, was written "Dc'd (discontinued) 2-13-13..." Observation of the resident on April 9, 2013, from 2:58 p.m., until 3:10 p.m., revealed the resident was in a wheelchair, alert and oriented, and propelling self around the facility independently. Interview and medical record review with Registered Nurse #1 on April 10, 2013, at 8:30 a.m., at the B Unit nursing station, confirmed the Physician wrote an order to discontinue the Hydroxyzine on February 13, 2013, and the resident continued to receive the medication on March 5-21, 23-25, 27-29, 31, 2013, and April 1-7, 2013.	F 329	How will corrective action be monitored? Licensed nurses for night shift conduct a nightly chart check for compliance with MD orders related to medications and other physician directives. ADONs on each unit will do weekly spot checks (20%) to determine accuracy and compliance with MD orders. ADONs will report these findings to the Performance Improvement committee (Administrator, DON, ADON's, SSD, Dietary Mgr, Maint Director, Env Services, Director, Medical Director, Business Office Manager, HR Director, Chaplain, and Admissions Director) monthly for 3 months and then committee will make any further recommendations as to additional audits if necessary.	5/10/13
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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	F 514		

Apr. 26. 2013 11:47AM No. 5269 P. 11

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F 514	Continued From page 10 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for two residents (#90, #5) of thirty-nine residents reviewed. The findings included: Resident #90 was admitted to the facility on January 15, 2010, with diagnoses including Congestive Heart Failure, Aortic Stenosis, Hypertension, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypothyroidism, Renal Insufficiency, Dementia, Peripheral Artery Disease, Depression, and Insomnia. Medical record review of a Physician's Progress Note dated April 3, 2013, revealed "...Mechanical heart valve w (with)/Coumadin (anticoagulant) management-Will continue to keep INR (International Normalized Ratio/test for blood cloagulation) between 2 and 3.5..." Medical record review of a Physician's Order dated February 1, 2013, revealed "Cont. (continue) Coumadin 1.5mg (milligrams) PO (by mouth) daily. Repeat PT(Prothrombin Time)/INR 1 week 2-8-13" Medical record review of a Laboratory Report dated February 8, 2013, revealed the PT was	F 514	F514 What corrective action will be accomplished for residents found to be affected by deficient practice? Resident #90 didn't have any adverse effects from not having labs dated. Unable to go back after the fact to add dates as Nurse Practitioner doesn't have a recollection of specific date that she may have reviewed those results from February 2013. Resident #5 has now had a behavioral flow sheet added to their chart/MAR for continued documentation. How will identify other residents having potential to be affected by same deficient practice? For all residents receiving labs, facility is now using the lab Quality Assurance form that tracks pending notifications of labs. This form is labeled 514-A as an attachment to this POC. Any residents receiving labs or needing behavioral monitoring sheets have potential to be affected if processes are not followed.	5/10/13 5/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445382		04/10/2013

NAME OF PROVIDER OR SUPPLIER
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F 514	Continued From page 11 35.6 (reference range 11.5 - 15.0) and the INR was 3.63 (reference range 0.86 - 1.16). Medical record review revealed the laboratory report dated February 8, 2013, was initialed by the Nurse Practitioner, however, the initials were not dated to indicate when the Laboratory Report was initialed. Medical record review of the Coumadin Administration Prothrombin Time Flow Sheet for February 2013, revealed the PT/INR was to be obtained on February 8, 2013, however, the results of the PT/INR and notification of the Physician or Nurse Practitioner were not documented. Interview on April 10, 2013, at 9:00 a.m., with the Director of Nursing, in the conference room, confirmed the Laboratory Report obtained on February 8, 2013, was not dated when signed by the Nurse Practitioner and confirmed the Coumadin Administration Prothrombin Time Flow Sheet was not complete. Resident #5 was admitted to the facility on February 12, 2013, with diagnoses including Prostate Cancer, Osteomyelitis, Diabetes Mellitus II, Bipolar Disorder, Insomnia, and Adjustment Disorder. Medical record review of Physician's Orders and Medication Records for February, March, and April, 2013, revealed the resident was receiving: Gabapentin 400 milligrams (mg) four times a day for seven days from February 28 through March 6, 2013; Gabapentin 600 mg four times daily starting March 6, 2013; Hydroxyzine 25 mg at	F 514	What measures put into place or what systemic changes will you make to ensure deficient practice doesn't recur? Licensed nursing staff will be Inserviced on the lab Quality Assurance form to track notifications of labs. Licensed nurses will also be inserviced on the Coumadin flow sheets and filling those out completely. Licensed nurses will also be inserviced on proper documentation related to the behavioral monitoring flow sheets. This education will be conducted by the Staff Development coordinator and/or the Director of Nursing. How will corrective action be monitored? The lab Quality Assurance monitoring sheets are reviewed daily in the daily clinical meeting which is attended by DON, ADONs, SDC, Dietary Director, Social Services, MDS, Activities, Chaplain, and others as necessary. Coumadin flow sheets and behavioral monitoring flow sheets will be audited weekly X 4 weeks, and then monthly for 3 months to determine compliance levels. Results of these audits will be reported to the Performance Improvement committee monthly X 3 months and any further recommendations will be made by the committee as to ongoing need for additional audits or reviews.	5/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445382		04/10/2013

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F 514	Continued From page 12 bedtime for anxiety March 1 through April 7, 2013; and Alprazolam 0.5 mg three times daily as needed for anxiety with 22 doses given in March 2013. Medical record review of the Behavior/Interventions Monthly Flow Record from the pharmacy for March 2013, revealed flow records for Gabapentin (for seizures or neuropathy) 400 mg, Hydroxyzine (for anxiety and sedation) 25 mg, Alprazolam (for anxiety) 0.5 mg, and Gabapentin 600 mg. Further review of the flow records revealed no behaviors had been listed on the flow records and no documentation had been completed on the flow records. Interview with Registered Nurse #2 on April 10, 2013, at 8:45 a.m., at the B Unit nursing station, confirmed the monitoring sheets were sent from pharmacy for medications such as prns (as needed medications) and psychotropics. Further interview confirmed the Nurses were to document on the monitoring sheets for the targeted behavior for the medication and the March flow records had not been completed.	F 514		

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