

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/20/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWALL DR JEFFERSONVILLE, IN 47130			
(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
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: July 9, 10, 11, 13 and 20, 2012</p> <p>Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>The deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed July 30, 2012 by Dotty Walton, Medical Surveyor III.</p>			W0000			

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

TITLE

(X6) DATE

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

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W0342	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation and interview for 1 of 4 sampled clients (client #1), the nursing services failed to ensure staff administering medications know how to use an atomizer with an inhaler.</p> <p>Findings include:</p> <p>The medication pass was observed on 7/10/12 starting at 6:05 AM. Client #1 received his medication at 7:30 AM. Staff #4 passed the medications and called client #1 to come to the medication room. Client #1 sat down at a small desk and staff #4 handed the atomizer and the inhaler, Flovent HFA (fluticasone propionate with propellant), to the client. The Flovent is used for asthma. Client #1 inserted the Flovent HFA into the atomizer. The mouth piece on the atomizer was turned wrong and the client didn't seem to know how to turn the mouth piece. The staff indicated she did not know how to use the atomizer with the inhaler. Staff #4 took the atomizer</p>	W0342	<p>W342: Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventative health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness, and basic skills required to meet the health needs of the clients.</p> <p>Corrective Action: (Specific) The Nurse will in service all staff on how to use an atomizer with an inhaler.</p> <p>How others will be identified: (Systemic) Medication observations will be done periodically by the Nurse and Program Coordinator.</p> <p>Measures to be put in place: All staff will be in serviced on how to use an atomizer with an inhaler.</p> <p>Monitoring of Corrective Action: The Director of Health services will periodically conduct</p>	08/11/2012			

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	<p>and adjusted the mouth piece and handed it back to client #1. Client #1 took the atomizer and started inhaling making the atomizer make a whistle sound. The client had not pushed down on the inhaler to make the medication go into the atomizer. The client handed the atomizer and inhaler back to staff #4 who preceded to put the medication away. Staff #3, Licensed Practical Nurse (LPN), was in the home and came into the medication room after client #1 had finished with his medicine.</p> <p>The interview with Staff #3, LPN, and staff #4 was conducted on 7/10/12 at 7:45 AM. Staff #3, LPN, was asked to explain how the atomizer was to be used with the inhaler. Staff #4 indicated the client had not pushed down on the inhaler for the require two puffs. Staff #3, LPN, ensured client #1 redid the atomizer with Flovent. Staff #3, LPN, indicated the staff should have known the inhaler had to be depressed to get the medication into the atomizer.</p> <p>9-3-6(a)</p>		<p>medication observations, and review medication observations completed by the Nurse and Program Coordinator.</p> <p>Completion date: 8/11/12</p>		