

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374
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F0000	<p>This visit was for the Investigation of Complaint IN00120654.</p> <p>Complaint IN00120654 -- Substantiated. Federal/State deficiency related to the allegations is cited at F333.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: December 11 and 12, 2012</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100288220</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 127 Total: 127</p> <p>Census payor type: Medicare: 24 Medicaid: 87 Other: 16 Total: 127</p> <p>Sample: 4</p> <p>These deficiencies reflect state</p>	F0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.	

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

TITLE

(X6) DATE

Any 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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	findings cited in accordance with 410 IAC 16.2.  Quality review 12/14/12 by Suzanne Williams, RN				

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to ensure an extended-release pain medication, MS Contin [an extended-release type of morphine sulfate], was not crushed prior to administration to a resident, which could cause respiratory depression, for 1 of 3 residents reviewed for accuracy of medication administration in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 12-11-12 at 12:40 p.m. His diagnoses included, but were not limited to, multiple myeloma, prostate cancer, bladder cancer, urostomy, paraplegia, anxiety and depression.</p> <p>Review of his medications indicated he was physician ordered to received MS Contin 300 mg (milligrams) every 8 hours by mouth for chronic pain control.</p> <p>A nursing progress note, dated 9-26-12 at 6:02 p.m. and signed by LPN #1, indicated, "This writer crushed resident's Morphine [sic]</p>	F0333	<p><b>F333</b></p> <p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p><b>Resident A expired on 11/19/2012.</b></p> <p><b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <p><b>Mandatory in-service for licensed nurses was held on 12/21/12. Medication administration test and medications that cannot be crushed list was given to each nurse and placed on each medication cart.</b></p> <p><b>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</b></p> <p><b>LPN#1 was counseled on medications that cannot be crushed. LPN did follow protocol on 9/26/12 after med</b></p>	12/21/2012	

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	<p>extended release tab...family aware and MD notified. MD states to monitor resp. [respirations]." Documentation for the following 5 hours indicated the resident's vital signs remained within normal range.</p> <p>In interview with LPN #1 on 12-11-12 at 2:45 p.m., she indicated on 9-26-12, she had gone into Resident #A's room to administer his 4:00 p.m. dose of morphine 300 mg around 4:30 p.m. She indicated the resident's wife asked what medication was being given. She indicated she told her that she had the resident's 4:00 p.m. dose of morphine and his 5:00 p.m. dose of an anti-anxiety agent. She indicated she had crushed these medications and "I have no idea why I crushed his meds; he didn't normally get his meds crushed." She indicated while she was talking with the wife, the resident "had gone ahead and taken them [the medications] as she was asking." She indicated she notified the physician of the occurrence and he told her to monitor the resident's respirations and to call him back with any changes. She indicated she monitored his vital signs at least hourly and he seemed to have no adverse effects.</p>		<p><b>error with no adverse reactions.</b> <b>Deficient practice with be monitored monthly through QA&amp;A process.</b></p> <p><b>Appropriate employee discipline will be followed for failure to follow facility policy.</b></p> <p><b>Pharmacy will supply updated list quarterly of medications that cannot be crushed and they will be distributed to all licensed nursing staff</b></p> <p><b>DNS/Designee will monitor medication pass 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly for 18 weeks on different shifts.</b></p> <p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	<p>Review of "2010 Nursing Spectrum Drug Handbook," for morphine indicated, "Don't crush or break extended-release form...may cause respiratory depression...."</p> <p>On 12-12-12 at 1:17 p.m., the Director of Nursing provided a copy of a policy entitled, "Medication Administration -- General Guidelines," with a revision date of 5/12. This policy indicated, "Long-acting or enteric-coated dosage forms should not be crushed...."</p> <p>This Federal tag relates to Complaint IN00120654.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				

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F0431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure one oral medication for an individual resident and 11 bottles of</p>	F0431	<p><b>F431</b></p> <p><b>The corrective actions accomplished for those</b></p>	12/21/2012	

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	<p>insulin for 8 individual residents were not left unattended on top of 2 of 4 medication carts during 1 of 2 medication pass observations with 2 of 4 licensed nurses. (LPN #4 and LPN #5)</p> <p>Findings include:</p> <p>During a medication pass observation on 12-12-12 at 8:45 a.m. with LPN #5, 3 bottles of Humalog insulin, 1 bottle of Lantus insulin, 1 bottle of Novolog insulin, for 4 individual residents, and 1 medication card with one dose of Buspar 5 mg for an individual resident were observed to be unattended on top of the medication cart on one hallway. In interview with LPN #5 on the same date at 9:13 a.m., she indicated she leaves the insulin out until she returns them to the refrigerator. She indicated the Buspar should have been placed back into a drawer in the medication cart. Resident names were not visible unless the medications were picked up.</p> <p>During a medication pass observation on 12-12-12 at 9:26 a.m. with LPN #4, 3 bottles of Humalog insulin and 3 bottles of Lantus insulin, for 4 individual residents, were observed to be unattended on top of the</p>		<p><b>residents found to have been affected by the deficient practice are as follows:</b></p> <p>LPN #4 and LPN #5 were given medication pass competency check offs by Director of Clinical Education. Expressed acknowledgement of proper handling and storage of medications.</p> <p><b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <p>Mandatory in-service for licensed nursing staff was held on 12/21/12. Topics covered were proper handling and storage of medications.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows</p> <p>DNS/Designee will monitor medication pass 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly for 18 weeks on different shifts.</p>		

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	<p>medication cart on another hallway. In interview with LPN #4 on the same date at 9:40 a.m., she indicated she doesn't always leaves the insulin out on top of the medication cart; she indicated if she has room in the medication cart, she places them in the cart. At 9:47 a.m., the insulin vials were placed in the medication cart by LPN #4. Resident names were not visible unless the medications were picked up.</p> <p>The Assistant Director of Nursing provided a written document on 12-12-12 at 5:40 p.m. which indicated none of the residents residing on the units in which the medication carts were located had "a history of taking items off of the desk, medication carts, or from others [sic] rooms."</p> <p>On 12-12-12 at 1:17 p.m., the Director of Nursing provided a copy of a policy entitled, "Medication Administration -- General Guidelines," with a revision date of 5/12. This policy indicated, "During administration of medications, the medication cart is kept closed and locked when out of sight of medication nurse or aide. No medications are kept on top of the cart..."</p>		<p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	3.1-25(m)				

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F0441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to</p>	F0441	<b>F441</b>	12/21/2012			

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	<p>ensure:</p> <p>A. appropriate disinfection of the blood glucose monitor [glucometer] was conducted when used between residents during 1 of 2 medication pass observations with 4 licensed nurses (RN #1). This had the potential to affect 36 residents identified by the facility as having a diagnosis of diabetes.</p> <p>B. medications were not touched by staff's bare hands during preparation of medications for 1 of 7 residents observed during 1 of 2 medication pass observations with 4 licensed nurses. (LPN #4, Resident #D)</p> <p>Findings include:</p> <p>A. During a medication pass observation on 12-11-12 with RN #1 at 4:02 p.m., she was observed to clean the glucometer after use with a 70% alcohol pad. In interview with RN #1 at 4:03 p.m., she indicated the facility provides one glucometer for each medication cart. She indicated, "We're supposed to have bleach wipes, but I don't have any on my cart. I would normally tell the medical supply person, but she's out of the building. I don't know how long they have been out on the cart; I was off for [the last] 3 days."</p> <p>On 12-11-12 between 5:27 p.m. and 5:45 p.m., interviews were conducted with the</p>		<p><b>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</b></p> <p>LPN # 1 and LPN #3 were counseled on proper cleaning of glucometers per CDC guidelines and facility police. Both signed acknowledgement of understanding. LPN # 4 was counseled on proper handling of medication using gloves to prevent contamination.</p> <p><b>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</b></p> <p><b>Mandatory in-service was held on 12/21/12 for licensed nursing staff. Topics covered were cleaning of glucometers, proper handling of medications. All nurses signed acknowledgement of understanding. Also included in the in-service was proper handling of medications with gloves to prevent contamination.</b></p> <p><b>The measures put into place and the systemic changes</b></p>		

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	<p>Administrator, RN #1, RN #2, RN #3, RN #4, LPN #1, LPN #2, and LPN #3 regarding disinfecting of glucometers. In interview with RN #1, she demonstrated the presence of a container of disinfecting wipes on the medication cart which indicated, "Bleach-Free, " with the active ingredients of dimethyl benzyl choride 0.184% and ethyl benzyl ammonium 0.184%.</p> <p>In interview with the Administrator, he indicated he had dispensed the bleach-free wipes just moments before to the nursing staff, prior to being interviewed . He indicated, "I accept full responsibility for that. All I saw was the 'Clorax' and 'disinfectant' [on the label]."</p> <p>In interview with RN #2, she indicated the facility normally used bleach wipes to disinfect glucometers.</p> <p>In interview RN #3, she indicated the facility used a bleach wipe indicated for healthcare use with the active ingredient listed as sodium hypochlorite 0.55% (bleach.)</p> <p>In interview RN #4, he indicated the facility used a bleach wipe indicated for healthcare use with the active ingredient listed as sodium hypochlorite 0.55% (bleach.) He demonstrated the presence</p>		<p><b>made to ensure that this deficient practice does not recur are as follows:</b></p> <p><b>DNS/Designee will monitor medication pass 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly for 18 weeks on different shifts.</b></p> <p><b>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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	<p>of the same on the medication cart he was using at the time of the interview.</p> <p>In interview with LPN #1, she indicated staff are to use bleach wipes to clean the glucometers. She demonstrated the presence of a container of disinfecting wipes on the medication cart which indicated, "Bleach-Free, " with the active ingredients of dimethyl benzyl choride 0.184% and ethyl benzyl ammonium 0.184%.</p> <p>In interview with LPN #2, she indicated she uses the alcohol wipes to clean the glucometer between uses "because they're right here and easy to get to." She indicated the alcohol pads were in the top drawer of the medication cart. She demonstrated the presence of sodium hypochlorite 0.55% (bleach) wipes on the medication cart she was using at the time which were located in the bottom drawer of the medication cart.</p> <p>In interview with LPN #3, she indicated she uses the bleach wipes to clean the glucometer between uses. She demonstrated the presence of sodium hypochlorite 0.55% (bleach) wipes on the medication cart she was using at the time.</p> <p>In interview with the Assistant Director of Nursing (ADON) on 12-11-12, she</p>			

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	<p>indicated, "We've had this conversation before in regards to the cleaning of the glucometers...The manufacturer says to use a 10% bleach solution or 70% alcohol. Our alcohol pads are 70% alcohol."</p> <p>On 12-12-12 at 10:50 a.m., the ADON provided a copy of a policy entitled, "Blood Glucose Monitor Decontamination, " with a revision date indicated as 8/12. This policy indicated, "A wipe that is an EPA registered as tuberculocidal; effective against HIV, HBV and a broad spectrum of bacteria will be utilized to clean the monitor. It is 0.0525% sodium hypochlorite which is equivalent to a 1:10 bleach dilution solution, and meets recommendation for use on equipment from <i>Clostridium difficile</i> rooms. If a product wipe is not available, a 1:10 bleach solution may be substituted. The blood glucose monitor will be cleaned and disinfected with wipes followed use on each resident when monitors are shared by multiple residents..." Attached to this policy was the manufacturer's recommendations, with no date indicated, which indicated, "Cleaning Your Monitor...Healthcare professionals: Acceptable cleaning solutions include 10% bleach, 70% alcohol, or 10% ammonia..." These recommendations also included a copy of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/12/2012
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	<p>the facility's alcohol pads, which indicated the active ingredient was 70% isopropyl alcohol.</p> <p>B. During a medication pass observation on 12-12-12 at 9:26 a.m. with LPN #4, she was observed to open a capsule of Cardizem CD 120 mg with ungloved hands and place the contents of the capsule into applesauce prior to the administration of the medication for Resident #D. In interview with LPN #4 on the same date at 9:40 a.m., she indicated she opened the capsule, but did not touch or crush the contents of the capsule.</p> <p>On 12-12-12 at 1:17 p.m., the Director of Nursing provided a copy of a policy entitled, "Medication Administration -- General Guidelines," with a revision date of 5/12. This policy indicated, "Wearing examination gloves when handling tablets [or capsules] is preferred. Examination gloves must be worn if the tablet [or capsule] requires special handling..."</p> <p>3.1-18(b)</p>				