

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 6, 7, 8, 9, 10, and 13, 2012</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Rick Blain, RN - TC Sue Brooker, RD Diane Nilson, RN Angela Strass, RN</p> <p>Census bed type: SNF/NF: 138 Total: 138</p> <p>Census payor type: Medicare: 13 Medicaid: 96 Other: 29 Total: 138</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 16, 2012 by Bev Faulkner, RN</p>	F0000	<p>This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Fort Wayne for the recent annual survey dated 8/13.12.</p> <p>Kindred-Fort Wayne asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action. The staff of Kindred-Fort Wayne is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Fort Wayne is in substantial compliance as set forth below, we are confident that it will be found in substantial compliance with regulations upon re-survey. The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</p>	

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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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of 1 resident (Resident #135) when his medication to help control his tremors due to Parkinson's</p>	F0157	1. LPN #10 was addressed relative to the need to notify resident's physicians if medications are not available Resident #135 did not incur any negative outcome as a result of	09/10/2012			

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	<p>disease was not available as ordered, in a total sample of 40 residents.</p> <p>Findings include:</p> <p>Resident #135 was interviewed on 8/8/12 at 1:45 p.m., at his request. During the interview he indicated he goes to church every Sunday with a member of the church and takes his medications with him when he leaves the facility which is usually around 9:00 a.m. He also indicated on 7/22/12, LPN #10 knew he needed his medication and she informed him she couldn't find his prescribed Stalevo, which he indicated he took three times a day for Parkinson's disease. He further indicated he assumed if she could not find the Stalevo, the PRN Sinemet (also for Parkinson's disease) would be sent. Resident #135 also indicated on the morning of 7/22/12, LPN #10 gave his medication to the church member who was taking him to church. LPN #10, informed the church member Resident #135's Parkinson's medication of Stalevo was not available and he would have to do without. Resident #135 further indicated he continued on to church and once at the church, he contacted his girlfriend who brought him enough Sinemet from home to the church for</p>		<p>not receiving the medication.</p> <p>2. Medication Administration Records (MARs) will be audited for the previous 30 days to identify any other residents who did not receive medication as ordered. Any identified concerns will be communicated to physicians with corrective action completed.</p> <p>3. Licensed nurses have received in-service education relative to physician notification, including but not limited to notifying physicians if medications are not available for administration. A performance improvement tool has been developed to monitor notification of physicians. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled work days of work, across all 3 shifts, for 30 days. Any concerns will be immediately addressed with the responsible individual(s). Thereafter, Director of Nursing, or designee, will monitor physician notification randomly during the week prior to monthly PI committee meeting, on at least 5 residents, for a minimum of 5 months. Any concerns will be immediately addressed with the responsible individual(s).</p> <p>4. Director of Nursing will review findings weekly and report findings to PI committee monthly for six months.</p>				

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	<p>him to have throughout the day. He indicated he did not receive any doses of Stalevo on Sunday, but did receive the medication on Monday. He indicated he could visually identify the different medications he took, including the Sinemet and the Stalevo. Resident #135 also indicated his tremors would start without his medication and once they started he could not control them. He also indicated he was embarrassed when his tremors started, especially when he was in public.</p> <p>Review of the clinical record for Resident #135 on 8/8/12 at 2:01 p.m., indicated the following: diagnoses included, but were not limited to, paralysis agitans, and anxiety.</p> <p>A physician Progress Note for Resident #135, dated 1/16/12, indicated "... Parkinson's disease on treatment...."</p> <p>A Minimum Data Set assessment for Resident #135, dated 6/4/12, indicated he scored a 15 out of 15 on the Brief Interview for Mental Status, indicating he was cognitively intact.</p> <p>A physician's order for Resident #135, dated for month of August, 2012, indicated Sinemet 25/100 tablet at</p>		5. Completion Date: September 10, 2012				

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	<p>6:00 a.m., Stalevo 200 mg (milligrams) TID (three times a day), and Sinemet 25/100 tablet 1 every 4 hours PRN (as needed) limit 2 doses in 24 hours.</p> <p>The Medication Administration Record (MAR) for Resident #135, for the month of July, 2012, indicated on 7/22/12, Resident #135 received the Sinemet ordered at 6:00 a.m., but did not receive the Stalevo ordered TID. The MAR also indicated no Sinemet PRN was given on 7/22/12. The nurse's medication notes on 7/22/12 indicated the Stalevo was not available in the facility.</p> <p>LPN #11 was interviewed on 8/9/12 at 8:48 a.m. During the interview she indicated Resident #135 received both Sinemet and Stalevo for his Parkinson's disease. She also indicated the PRN Sinemet was usually given during the night shift when he would wake up from sleeping and was concerned his tremors would start. She further indicated she had never had to give him his PRN Sinemet since his Stalevo was always available in the facility.</p> <p>The Director of Nursing Services was interviewed on 8/9/12 at 2:55 p.m.</p>			

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	<p>During the interview she indicated Resident #135 did not receive his Stalevo TID or PRN Sinemet from the facility on 7/22/12. She also indicated she could not determine if staff should have provided the PRN Sinemet when the ordered Stalevo was not available.</p> <p>A facility Complaints/Grievances form for Resident #135, dated 7/23/12, indicated LPN #10 said his morning and afternoon doses of Stalevo were not available in the med cart on 7/22/12. The form also indicated Resident #135's girlfriend had his medication at home and gave it to him so he did not miss a dose. The form further indicated other nurses indicated the Stalevo was in the medication cart the entire time.</p> <p>A fax to Resident #135's physician, dated 7/24/12 and provided by the Director of Nursing Services on 8/9/12 at 3:30 p.m., indicated he was contacted concerning Resident #135's medication of Tramadol, but did not indicate he was informed of Resident #135 not receiving his Stalevo.</p> <p>A current facility policy "Medication Administration", dated 8/31/11 and provided by the Director of Nursing</p>						

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	<p>Services on 8/9/12 at 3:20 p.m., indicated "...distribute physician ordered medications to patients...document withheld, refused, or medications given at other than the scheduled time by circling initialed space and providing an explanation of the reverse side of MAR...notification of physician of withheld, refused, or medications given at other than scheduled times...."</p> <p>3.1-5(a)</p>			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility staff failed to ensure encouragement and/or assistance was provided during meal time for 2 residents (Resident #2 and Resident #116) in the assist dining room at the same time their tablemates were eating their meals.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the assisted dining room on 8/7/12 at 12:00 p.m., Resident #2 was observed seated in a wheelchair at a table in the dining room and had received her lunch tray, along with her 3 tablemates. She was observed seated with her head down and at 12:14 p.m., had not taken a bite of food or a sip of fluids. The other residents seated at her dining table were observed eating their lunch meals. No staff in the assist dining room were observed to encourage her to eat or to provide her any assistance with her lunch tray.</p>	F0241	<p>1. Residents #116 and #2 did not incur any negative outcomes as a result of the care provided.</p> <p>2. All residents requiring assistance with meal service have the potential to be affected; therefore this plan of correction applies to those residents.</p> <p>3. Nursing center staff has received in-service education relative to dignity and respect of individuals, including but not limited to the necessity and importance of assisting residents promptly during meals. A performance improvement tool has been developed to monitor provision of assistance with meals. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled work days of work, across all 3 meals, for 30 days. Any concerns will be immediately addressed with the responsible individual(s). Thereafter, Director of Nursing, or designee, will monitor meals randomly during the week prior to monthly PI committee meeting, during at least 5 meals, for a minimum of 5</p>	09/10/2012			

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	<p>At 12:22 p.m., Resident #2 remained seated in her wheelchair in the assist dining room with her head down. She had not taken a bite of food or a sip of fluids. The other resident seated at her dining table were observed eating their lunch meals. No staff in the assist dining room were observed to encourage her to eat or to provide her any assistance with her lunch tray.</p> <p>At 12:23 p.m., Certified Nursing Assistant (CNA) #12 was observed to approach the dining table where Resident #2 was seated and talk with her tablemate. She was not observed to encourage Resident #2 to eat or to provide her any assistance with her lunch tray.</p> <p>At 12:25 p.m., CNA #12 was observed to approach Resident #2 in the assisted dining room and encouraged her to eat. Resident #2 was only observed to take a sip of fluid at 12:27 p.m., and CNA #12 was observed to walk away from her.</p> <p>At 12:30 p.m., RN #13 was observed to approach Resident #2, asking her why she did not want to eat. Encouragement was offered, but declined by Resident #2.</p> <p>CNA #12 was interviewed on 8/7/12</p>		<p>months. Any concerns will be immediately addressed with the responsible individual(s).</p> <p>4. Director of nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>				

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	<p>at 12:30 p.m. During the interview, she indicated Resident #2 required a lot of encouragement and prompting to eat and drink at mealtime.</p> <p>2. During an observation of the lunch meal in the assisted dining room on 8/8/12 at 12:00 p.m., Resident #2 was observed seated in a wheelchair at a table in the dining room and had received her lunch tray. She was observed taking sips of her fluids, but was not observed taking bites of food. The other residents seated at her dining table were observed eating their lunch meals. No staff in the assist dining room were observed to encourage her to eat or to provide her any assistance with her lunch tray.</p> <p>At 12:15 p.m., Speech Therapist #14 was observed to enter the assist dining room, pull a chair over next to Resident #2 and begin to feed her. Prior to the Speech Therapist entering the assist dining room, no staff were observed to encourage Resident #2 to eat or to provide her any assistance with her lunch tray.</p> <p>The Admission Packet for the facility, provided by the Administrator on 8/9/12 at 4:20 p.m., indicated "...The Resident has a right to a dignified existence...."</p>						

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	<p>3. During observation of the noon meal in the assisted dining room on C wing, at 12:25 p.m., on 8/6/12, Resident #116 was observed sitting at the dining room table in a wheelchair with a blanket around her shoulders with a plate of pureed food in front of her. No one was assisting the resident with her meal and she was not feeding herself.</p> <p>There were approximately 30 residents in the assisted dining room and 10 staff were observed assisting other residents.</p> <p>Resident #116 was observed sitting without assistance until CNA #20 came to the table at 12:45 p.m., and asked the resident if she would like her food re-heated. CNA #20 then left the table with the resident's plate and returned to the table at 12:53 p.m., and sat down and started to feed the resident at 12:55 p.m. (30 minutes after the resident was first noticed with the food in front of her).</p> <p>CNA #20 was interviewed at 12:55 p.m., on 8/6/12, and indicated she did not normally feed this resident, but indicated sometimes the resident could feed herself.</p> <p>3.1-3(t)</p>				

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F0257 SS=E	<p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation, record review, and interview, the facility failed to ensure the room temperature in the assist dining room was maintained at a comfortable temperature, potentially affecting 29 residents who ate in the dining room.</p> <p>Findings include:</p> <p>During observation of the noon meal beginning at 11:36 a.m., on 8/9/12, 29 residents were observed in the assisted dining room. Nine (9) of the residents were noted to have blankets wrapped around their shoulders/upper bodies, and 8 other residents were noted to be wearing sweaters or jackets. An Indiana State Department of Health thermometer was utilized to check the room temperature at 11:37 a.m., and the temperature registered 65 degrees Fahrenheit.</p> <p>At 11:50 a.m., on 8/9/12, the Maintenance Director used the facility infra red thermometer to check the room temperature, which registered</p>	F0257	<p>1. There were no negative outcomes as a result of the temperatures.</p> <p>2. All residents who eat meals in the assisted dining room have the potential to be affected; therefore this plan of correction applies to those residents.</p> <p>3. Nursing center staff has received in-service education relative to comfortable and safe temperature levels, including but not limited to ensuring that the temperature in the assisted dining room is comfortable for the residents.</p> <p>A performance improvement tool has been developed to monitor environmental temperatures. Executive Director, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled days of work, 3 times a day, for 30 days. Any concerns will be immediately addressed with the maintenance department. Thereafter, Executive Director, or designee, will monitor temperatures randomly during the week prior to monthly PI committee meeting, on at least 5 days, for a minimum</p>	09/10/2012			

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	<p>64 degrees Fahrenheit. The Maintenance Director indicated the wall thermometer in the dining room indicated the temperature in the room was 65 degrees Fahrenheit. He indicated he had to keep the temperature a little cooler in the hall outside the dining room because when the door (which was located off the hall across from the dining room) to the outside courtyard was opened, hot air would come into the hall. At 12 noon, the Maintenance Director indicated the temperature in the room was 65 degrees Fahrenheit.</p> <p>Ten of the 29 residents in the assisted dining room were interviewed, between 11:36 a.m. and 12 noon on 8/9/12, and indicated the dining room temperature was cold.</p> <p>Review of the Resident Council Minutes, provided by the Activity/Social Service Director at 8:50 a.m., on 8/10/12, indicated during the Resident Council meeting held on June 13, 2012, residents complained of dining rooms being either too hot or too cold.</p> <p>The Administrator was interviewed at 9:10 a.m., on 8/10/12, and indicated the Maintenance Director did not keep logs for environmental</p>		<p>of 5 months. Any concerns will immediately be addressed with maintenance.</p> <p>4. Executive Director will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012.</p>				

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	temperatures, and this was not done as part of the routine maintenance duties. 3.1-19(h)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician orders for medication to control tremors for 1 resident (Resident #135) with Parkinson's disease of 10 residents who met the criteria for unnecessary medications. The facility also failed to ensure vital signs were obtained as ordered by the physician for 1 of 10 residents who met the criteria for unnecessary medications (Resident #100).</p> <p>Findings include:</p> <p>1. Resident #135 was interviewed on 8/8/12 at 1:45 p.m., at his request. During the interview he indicated he goes to church every Sunday with a member of the church and takes his medications with him when he leaves the facility which is usually around 9:00 a.m. He also indicated on 7/22/12, LPN #10 knew he needed his medication and she informed him she couldn't find his prescribed Stalevo, which he indicated he took</p>	F0282	<p>1. Residents #100 and #135 did not incur any negative outcomes as a result of the care provided.</p> <p>2. Medication Administration Records (MARs) will be audited for the previous 30 days to identify any other residents who did not receive medication as ordered, or who did not have vital signs obtained and documented as ordered. Any identified concerns will be communicated to physicians with corrective action completed.</p> <p>3. Licensed nursing staff has received in-service education relative to services by qualified persons/per care plan, including but not limited to following physician orders for medications and obtaining of vital signs. A performance improvement tool has been developed to monitor provision of medication and obtaining of vital signs in accordance with physician orders. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled working days of work, 5 times a week, for 30 days. Any concerns will be immediately</p>	09/10/2012			

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	<p>three times a day for Parkinson's disease. He further indicated he assumed if she could not find the Stalevo, the PRN Sinemet (also for Parkinson's disease) would be sent. Resident #135 also indicated on the morning of 7/22/12, LPN #10 gave his medication to the church member who was taking him to church. LPN #10, informed the church member Resident #135's Parkinson's medication of Stalevo was not available and he would have to do without. Resident #135 further indicated he continued on to church and once at the church, he contacted his girlfriend who brought him enough Sinemet from home to the church for him to have throughout the day. He indicated he did not receive any doses of Stalevo on Sunday, but did receive the medication on Monday. He indicated he could visually identify the different medications he took, including the Sinemet and the Stalevo. Resident #135 also indicated his tremors would start without his medication and once they started he could not control them. He also indicated he was embarrassed when his tremors started, especially when he was in public.</p> <p>Review of the clinical record for Resident #135 on 8/8/12 at 2:01 p.m.,</p>		<p>addressed with responsible individuals. Thereafter, Director of Nursing, or designee, will monitor provision of medication and obtaining of vital signs randomly during the week prior to monthly PI committee meeting, on at least 3 days, for a minimum of 5 months. Any concerns will immediately be addressed with responsible individuals.</p> <p>4. Director of Nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>				

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	<p>indicated the following: diagnoses included, but were not limited to, paralysis agitans, and anxiety.</p> <p>A physician Progress Note for Resident #135, dated 1/16/12, indicated..." Parkinson's disease on treatment...."</p> <p>A Minimum Data Set assessment for Resident #135, dated 6/4/12, indicated he scored a 15 out of 15 on the Brief Interview for Mental Status, indicating he was cognitively intact.</p> <p>A physician's order for Resident #135, dated for month of August, 2012, indicated Sinemet 25/100 tablet at 6:00 a.m., Stalevo 200 mg (milligrams) TID (three times a day), and Sinemet 25/100 tablet 1 every 4 hours PRN (as needed) limit 2 doses in 24 hours.</p> <p>The Medication Administration Record (MAR) for Resident #135, for the month of July , 2012, indicated on 7/22/12, Resident #135 received the Sinemet ordered at 6:00 a.m., but did not receive the Stalevo ordered TID. The MAR also indicated no Sinemet PRN was given on 7/22/12. The nurse's medication notes on 7/22/12 indicated the Stalevo was not available in the facility.</p>						

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	<p>A Resident Progress Notes for Resident #135, dated 7/22/12, did not contain an entry addressing the Stalevo not available in the building or physician notification.</p> <p>The Director of Nursing Services was interviewed on 8/9/12 at 2:55 p.m. During the interview she indicated Resident #135 did not receive his Stalevo TID or PRN Sinemet from the facility on 7/22/12, but his girlfriend did bring him his PRN Sinemet from home after he notified her he did not have any. She also indicated she could not determine if staff should have provided the PRN Sinemet when the ordered Stalevo was not available.</p> <p>A facility Complaints/Grievances form for Resident #135, dated 7/23/12, indicated LPN #10 said his morning and afternoon doses of Stalevo were not available in the med cart on 7/22/12. The form also indicated Resident #135's girlfriend had his medication at home and gave it to him so he did not miss a dose. The form further indicated other nurses indicated the Stalevo was in the medication cart the entire time.</p> <p>A current facility policy "Medication</p>			

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	<p>Administration", dated 8/31/11 and provided by the Director of Nursing Services on 8/9/12 at 3:20 p.m., indicated "...distribute physician ordered medications to patients...document withheld, refused, or medications given at other than the scheduled time by circling initialed space and providing an explanation of the reverse side of MAR...notification of physician of withheld, refused, or medications given at other than scheduled times...."</p> <p>The Director of Nursing Services was interviewed on 8/13/12 at 1:57 p.m. During the interview she indicated the facility did not have a specific policy on following physician orders. She also indicated it was assumed physician orders were to be followed.</p> <p>2. The record for Resident #100 was reviewed on 8/8/12 at 3:00 P.M. Diagnoses include, but were not limited to, hypertension (high blood pressure). Medications prescribed by the physician for Resident #100 included , but were not limited to, Verapamil (medication used to treat hypertension) 180 mg (milligrams) daily.</p> <p>A physician's order, dated 5/25/10, which was listed on the physician's order monthly recap for August 2012,</p>			

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	<p>indicated vital signs (blood pressure, temperature, pulse and respirations) were to be obtained weekly and documented on the Vital Sign flow sheet and on the Medication Administration Record (MAR).</p> <p>The Vital Signs flow sheet for Resident #100 indicated no vital signs had been documented since 7/3/2012.</p> <p>The MARS for Resident #100 for May, June, July, and August 2012 indicated no vitals signs had been documented since 5/22/2012.</p> <p>The Resident Progress Notes for Resident #100 indicated no vitals signs had been documented since 7/13/2012.</p> <p>Nurse #19 was interviewed on 8/8/12 at 3:30 P.M. During the interview, Nurse #19 indicated vital signs were to be obtained as ordered by the physician and recorded in the record. Nurse #19 indicated vital signs were to be recorded on the Vital Sign flow sheet and on the MAR, but sometimes the nursing staff also recorded vital signs in the Resident Progress Notes.</p> <p>3.1-35(g)(2)</p>				

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F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was transferred with a mechanical lift as care planned and incurred an acute left distal fracture of the femur (thigh bone) for 1 of 3 residents reviewed from the sample of 7 residents who met the criteria for accidents (Resident #95).</p> <p>Findings include:</p> <p>At 9:40 a.m., on 8/9/12, Resident #95 was observed asleep, sitting in a wheelchair in the Dining room, where an activity was in progress.</p> <p>The clinical record for Resident #95 was reviewed at 9:48 a.m., on 8/9/12, and indicated the resident was initially admitted on 10/19/07, and readmitted to the facility on 7/19/12 following surgical repair of a left leg fracture. Diagnoses included, but not limited to: congenital hemiplegia, osteoporosis, contractures, dementia without behaviors, hypertension,</p>	F0323	<p>1. LPN #6 has been re-educated relative to proper communication and documentation and CNA #s 2, 3, and 4 have been re-educated relative to proper transfer technique for Resident #95. Resident #95 has received follow-up care in accordance with the Orthopedic physicians orders. Resident #95's care plan and CNA assignment sheets have been reviewed and updated, as necessary, to reflect current interventions.</p> <p>2. All residents requiring use of a mechanical lift for transfers have the potential to be affected; therefore, this plan of correction applies to those residents.</p> <p>3. Nursing center staff have received in-service education relative to free of accidents/supervision/devices, including but not limited to ensuring use of mechanical lift for transfer of those residents requiring the same. A performance improvement tool has been developed to monitor proper transfer techniques. Staff Development Coordinator</p>	09/10/2012

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	<p>failure to thrive, and Alzheimer's disease.</p> <p>The care plan, dated on 7/11/12 and updated 7/31/12, indicated the resident was at risk for falls, was non ambulatory, and dependent for transfers.</p> <p>A resident progress note, dated 7/15/12, at 5:30 a.m., and signed by LPN #1, indicated a Certified Nursing Assistant (CNA) reported the resident's leg was slightly swollen and flaccid when repositioning the resident. The note indicated the LPN assessed the resident and the left leg was slightly swollen to the thigh, there was a slight bulge noted to the left knee area and it was slightly warm to the touch under the knee area. The note revealed the physician was notified, an xray ordered, and the resident was a Hoyer (mechanical lift) transfer, but no transfer had occurred. There was no previous documentation in the clinical record of any incidents occurring regarding this finding.</p> <p>Review of a follow-up report to the Indiana State Department of Health (ISDH), provided by the Administrator at 10:45 a.m., on 8/9/12, and dated 7/20/12, indicated on 7/15/12, at 5:30</p>		<p>(SDC), or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled working days of work, 5 times a week across all 3 shifts, for 30 days. Any concerns will be immediately addressed with responsible individuals. Thereafter, SDC, or designee, will monitor transfers randomly during the week prior to monthly PI committee meeting, on at least 3 transfers, for a minimum of 5 months. Any concerns will immediately be addressed with responsible individuals.</p> <p>4. Director of Nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>		

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	<p>a.m., Resident #95 was noted to have a flaccid left leg which was normally contracted related to congenital hemiplegia. The leg was warm to the touch behind the left knee, edema was noted to the left upper thigh, and the resident was essentially non-verbal. The resident pushed the staff away with care but this was normal for the resident, but the resident did moan with movement. The report indicated the resident returned to the facility on 7/19/12 following repair of a femur fracture, and the resident was to receive therapy. The report indicated the exact cause of the fracture remained unknown, however a history and physical from the Orthopedic physician revealed an acute left distal femur fracture versus subacute pathological fracture, and due to the resident's diagnoses of osteoporosis and osteopenia and the absence of a reported event, the fracture was likely pathological.</p> <p>The report also indicated the resident was up in a wheelchair daily with the use of a Hoyer lift with two staff assistance.</p> <p>The Director of Nursing Services was interviewed at 11:20 a.m., on 8/9/12, and provided further investigative</p>			

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	<p>interviews with various staff members regarding the incident. She indicated an investigation was completed and the facility could not determine a reason for the fracture.</p> <p>The statements from staff were reviewed at 11:30 a.m., on 8/9//12.</p> <p>A statement documented on a resident progress note, dated 7/14/12 at 2:00 p.m., and signed by CNA#3 indicated, "When I came in (Resident#95) was still in her chair. I came in her room and got linen to clean her up. I got (CNA#5) to spot me using the Hoyer lift to change her clothes, her pants brief and shirt were wet I changed all her clothes and put lift back under her got her back in the chair for dinner. (sic)"</p> <p>The statement from CNA#3 further indicated after dinner she got CNA#4 to spot her using the Hoyer lift to put the resident to bed. CNA#3 indicated she and CNA #4 attached the pad back to the lift and put the resident in bed, undressed her bottom half, and noticed her leg was "not right. " CNA#3 indicated she immediately notified the nurse.</p> <p>The Director of Nursing Services was interviewed at 1:47 p.m., on 8/9/12, and indicated she thought the incident occurred on 2nd shift. She indicated</p>			

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	<p>CNA #3 did not tell the truth, but this was not discovered until 4 days after the incident occurred. The Director of Nursing Services indicated she and the Administrator interviewed CNA #3 and CNA #4 on either 7/18 or 7/19/12, and discovered CNA #3 and CNA #4 lifted the resident into bed, and did not use the Hoyer lift. The Director of Nursing Services indicated during this meeting, CNA #3 admitted she had lied about the incident, and said she and CNA #4 did not use a Hoyer for the transfer. The Director of Nursing Services indicated LPN #6 did not have care of the resident on 7/14/12, but CNA #3 had reported to her regarding the resident's leg. LPN #6 however did not document what she had assessed until 7/15/12.</p> <p>CNA #4 was interviewed at 2:16 p.m., on 8/9/12, and indicated she had only taken care of the resident one time prior to 7/14/12 . She indicated she worked the day shift on 7/14/12, but did not have care of the resident that day. She indicated she also worked the evening shift on 7/14/12, but did not have care of the resident. She indicated at approximately 8:30 p.m., on 7/14/12, CNA#3 asked her to come and spot her for a transfer. CNA#4 indicated when she went into</p>			

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	<p>the room, the resident was in her wheelchair, but had a "grimacing look" on her face. She indicated the resident did not say anything, but had her left hand on her left thigh, and was clutching her thigh. She indicated she and CNA#3 proceeded to place the resident into bed using a 2 man lift. She indicated she didn't remember seeing a lift pad under the resident in her chair when they transferred the resident.</p> <p>CNA#4 indicated the resident was moaning and groaning when they transferred her to bed. She indicated when the resident was in bed, CNA#3 noticed her leg was "funny" and also said the leg did not look right. CNA #4 indicated she told CNA #3 that she should tell the nurse immediately .</p> <p>CNA #4 also indicated when she first started working in April, she was asked to assist with a transfer of Resident #95 and they had lifted the resident using a 2 man lift. She indicated she was not aware the resident was a Hoyer, 2 person assist, until this incident had occurred.</p> <p>LPN #6 was interviewed at 3:15 p.m., on 8/9/12. She indicated she had worked at the facility for a few months, but had previous experience as a nurse. She indicated she was</p>			

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	<p>working on another hall on 7/14/12, and CNA #3 asked her to come into Resident #95's room. She indicated this occurred sometime after supper, but she was not sure of the time. She indicated CNA #3 told her the resident's leg looked "strange," so CNA #3 wanted her to check the resident. LPN #6 indicated when she went into the room, the resident was laying in bed, and she looked at her leg. She indicated the resident was not in acute distress, and was smiling and giggling, and LPN #6 asked the resident if her leg hurt, and the resident shook her head, "no." LPN #6 indicated the leg looked swollen and looked a little deformed and the resident's legs were contracted. LPN #6 indicated she told CNA #3 she needed to let her nurse know about this. She indicated when she left the resident's room, she saw the resident's nurse in another room, and CNA #3 was right behind her (LPN#6). LPN #6 indicated she did not know if CNA #3 reported the incident to the resident's nurse, but indicated she (LPN #6) did not. LPN #6 also indicated she did not document what she had observed. LPN #6 indicated she was scheduled to work the next day on 7/15/12, and the Director of Nursing asked her to document a statement about the</p>						

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	<p>incident. She indicated as far as she could recall, there was a Hoyer pad under the resident, but indicated, "can't be 100% positive Hoyer pad was under her." She indicated she had taken care of this resident prior to this incident, and had helped to put resident in bed several times using the Hoyer lift.</p> <p>CNA #2 was interviewed on the telephone, at 3:27 p.m., on 8/9/12. She indicated she was working the night shift on 7/14 to 7/15/12, and had care of the resident. She indicated normally if the resident was not wet on first rounds, she would be on 2nd and 3rd rounds. She indicated that night the resident was dry on the 1st and 2nd rounds, but had been incontinent on the 3rd round. She indicated when she went into the resident's room, the resident was whimpering more than usual that morning, and when she turned the resident, she was whimpering more and pushing at the CNA. She indicated when she turned the resident the other way, her "leg moved like jello" so she went and got LPN #1 who came down and checked the resident.</p> <p>CNA#2 indicated the resident's leg was more swollen than usual and "looked funny" and she knew</p>			

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	<p>something was not right. She indicated she came to work at 10:00 p.m., on 7/14/12, and started passing ice in the resident's room about 10:15 p.m., after she got report. She indicated she did not check or turn the resident at this time. She indicated she went back to the resident's room about 12:30 a.m. or so, and checked the resident and pulled her blanket back and the pads under the resident were not wet. She indicated the resident did not wear briefs at night, only a gown, and the pad under her was dry, so she did not turn the resident. She indicated she checked the resident again at 2-2:30 a.m., and the pad was still dry, so she did not touch the resident. She indicated the next time she went into the resident's room was approximately 4:30-5:00 a.m., and at this time, the resident was soaking wet. When she started washing the resident, she started whimpering more. She indicated the resident did not normally like to be bothered. She indicated when she turned the resident, her leg "looked like jello," so she reported this to the nurse. CNA #2 indicated she did not notice anything unusual until that morning, and no one had reported there was anything wrong with the resident.</p>			
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	<p>CNA #3 was interviewed by telephone at 3:35 p.m., on 8/9/12 and indicated she had worked on 7/14/12, the evening shift. She indicated she didn't normally take care of Resident #95, but usually worked the opposite side of the hall. She indicated she had assisted with the resident before but never taken care of her. She indicated she had assisted with Hoyer transfers on the resident prior to this incident. She indicated on 7/14/12, she was assigned to the resident. She indicated all of the CNAs worked as a group, and would talk and communicate with each other. She indicated the CNA on the prior shift would report about the residents regarding their care. CNA #3 indicated the day shift CNA had told her she had not laid the resident down and the resident needed changed and had to get up for supper.</p> <p>CNA #3 indicated the facility policy on the Hoyer lift required 2 staff be present during a Hoyer transfer. She indicated the resident was in her wheelchair when she came to work. She indicated she asked CNA #5 to spot her using the Hoyer lift so she could transfer the resident to bed and change her. She indicated CNA #5 spotted her during the transfer, but did not touch the Hoyer. CNA #3</p>			
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	<p>indicated she changed the resident, cleaned her, that she was still on the Hoyer pad, then CNA #5 spotted her using the Hoyer to place the resident back in her chair for supper. CNA#3 indicated after supper, she completed care on the other residents, and could not find a Hoyer to use to put Resident #95 to bed. She indicated she asked CNA #4 to come to the resident's room, and together they transferred the resident to bed, using a 2 person lift, but did not use the Hoyer. She indicated after she and CNA #4 had transferred the resident to bed and changed her, she removed the resident's pants and noticed from the resident's knee to her thigh was "just huge," so she told CNA#4 to get the nurse. She indicated LPN #6 then came into the room and assessed the resident. She indicated LPN #6 did not report her findings to the other nurse, and she would have told the other nurse, but could not find her. She indicated LPN #6 did not tell her to report to the other nurse and she left without telling the resident's nurse.</p> <p>She indicated she received a disciplinary action for not using the Hoyer lift and received additional inservicing regarding use of the Hoyer.</p>			

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	<p>Review of the Certified Nursing Assistant assignment sheet, dated 7/14/12, provided by the Director of Nursing Services, at 9:10 a.m., on 8/10/12, and with CNA#3's name on the sheet, indicated the resident was a Hoyer 2 person assist for transfers.</p> <p>3.1-45(a)(1)</p>			

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F0371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food items stored in 2 of 2 pantry refrigerators were labeled and dated. This had the potential to affect 1 or up to 3 residents.</p> <p>Findings include:</p> <p>The pantry room refrigerator on B wing was observed, accompanied by the Assistant Director of Nursing at 8:30 a.m., on 8/13/12. One (1) of 2, 1/2 pint cartons of 2% milk, had no expiration date on the carton. There was no use by date embedded on the carton.</p> <p>At 9:10 a.m., on 8/13/12, and accompanied by the Dietary Manager, in the pantry room refrigerator on C wing, there were 3 small green containers of spinach salad. There were no labels or dates on the containers. The Dietary Manager indicated he thought the spinach</p>	F0371	<p>1. The 2% milk and the spinach salad were removed from the refrigerators and discarded at the time of discovery.</p> <p>2. No residents were affected, however, all residents have the potential to be affected. Therefore this plan of correction applies to all residents.</p> <p>3. Nursing center staff have received in-service education relative to food procure, store/prepare/serve – sanitary, including but not limited to proper storage of food and drinks in refrigerators.</p> <p>A performance improvement tool has been developed to monitor proper storage of food and drinks in refrigerators. Executive Director, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled working days of work, for 30 days. Any concerns will be immediately addressed with unit personnel. Thereafter, Executive Director, or designee, will monitor proper storage of food and drinks</p>	09/10/2012

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	<p>salad was served to the residents on 8/11/12. He indicated the kitchen staff would not have placed the containers in the refrigerator if the residents didn't eat the spinach salad. He indicated he didn't know why they were in the refrigerator, and they should have been placed on trays and removed by dietary staff if not consumed.</p> <p>Review of the "Food Storage Guide" policy, provided by the Director of Nursing Services at 12 noon on 8/13/12, indicated "individual foods prepared or set up for meal service and intended to be used within 1 day either have individual dates or, in the case of multiple items, the tray, container or carton is dated with the current date."</p> <p>3.1-21(i)(3)</p>		<p>randomly during the week prior to monthly PI committee meeting, on at least 3 days, for a minimum of 5 months. Any concerns will immediately be addressed with unit staff.</p> <p>4. Executive Director will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>		

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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired influenza vaccine was not stored in 2 of 2 medication rooms. The facility also failed to ensure medication for 1 resident (Resident #135) was available in the facility, in a total sample of 40 residents.</p> <p>Findings include:</p> <p>1. During observation of medication room on C wing at 9:48 a.m., on 8/6/12, accompanied by RN#18, there</p>	F0425	<p>1. 1. The vials of flu vaccine were discarded at the time of discovery. 2. Resident #135 did not incur any negative outcome as a result of not receiving the medication..</p> <p>2. All medication rooms and carts have been audited to ensure no expired medications are present. Medication Administration Records (MARs) will be audited for the previous 30 days to identify any other residents who did not receive medication as ordered with corrective action taken, as necessary.</p>	09/10/2012			

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	<p>was 1 opened multidose vial of influenza virus vaccine "flulaval," 3/4 full, with an expiration date of June 2012.</p> <p>In addition, there were 4 unopened vials, with expiration dates of June 2012 . The RN indicated the influenza vaccine was facility stock for the residents and staff.</p> <p>During observation of the B wing medication room, at 10:14 a.m., on 8/6/12, and accompanied by RN#19, the following was observed in the refrigerator in the medication room: 22 unopened Flulaval influenza vaccine vials in boxes dated as expired June 2012, and 1 opened vial of influenza vaccine, with an expiration date of June, 2012.</p> <p>Review of the policy for Storage of Medications, provided by the Director of Nursing Services, at 2:10 p.m., on 8/8/12, indicated, "Remove and dispose of according to procedures for medication disposal that are outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures from stock."</p> <p>2. Resident #135 was interviewed on 8/8/12 at 1:45 p.m., at his request. During the interview, he indicated he</p>		<p>3. Licensed nursing staff has received in-service education relative to pharmaceutical svc – accurate procedures, rph, including but not limited to storage of medications and availability of medications. A performance improvement tool has been developed to monitor proper storage of medication and medication availability. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled days of work, for 30 days. Any concerns will be immediately addressed with responsible personnel. Thereafter, Director of Nursing, or designee, will monitor medication storage and availability randomly during the week prior to monthly PI committee meeting, on at least 3 days, for a minimum of 5 months. Any concerns will immediately be addressed with responsible staff.</p> <p>4. Director of nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>				

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	<p>goes to church every Sunday with a member of the church and takes his medications with him when he leaves the facility which is usually around 9:00 a.m. He also indicated on 7/22/12, LPN #10 knew he needed his medication and she informed him she couldn't find his prescribed Stalevo, which he indicated he took three times a day for Parkinson's disease. He further indicated he assumed if she could not find the Stalevo, the PRN Sinemet (also for Parkinson's disease) would be sent. Resident #135 also indicated on the morning of 7/22/12, LPN #10 gave his medication to the church member who was taking him to church. LPN #10, informed the church member Resident #135's Parkinson's medication of Stalevo was not available and he would have to do without. Resident #135 further indicated he continued on to church and once at the church, he contacted his girlfriend who brought him enough Sinemet from home to the church for him to have throughout the day. He indicated he did not receive any doses of Stalevo on Sunday, but did receive the medication on Monday. He indicated he could visually identify the different medications he took, including the Sinemet and the Stalevo. Resident #135 also</p>			

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	<p>indicated his tremors would start without his medication and once they started he could not control them. He also indicated he was embarrassed when his tremors started, especially when he was in public.</p> <p>Review of the clinical record for Resident #135 on 8/8/12 at 2:01 p.m., indicated the following: diagnoses included, but were not limited to, paralysis agitans, and anxiety.</p> <p>A physician Progress Note for Resident #135, dated 1/16/12, indicated "Parkinson's disease on treatment."</p> <p>A Minimum Data Set assessment for Resident #135, dated 6/4/12, indicated he scored a 15 out of 15 on the Brief Interview for Mental Status, indicating he was cognitively intact.</p> <p>A physician's order for Resident #135, dated for month of August, 2012, indicated Sinemet 25/100 tablet at 6:00 a.m., Stalevo 200 mg (milligrams) TID (three times a day), and Sinemet 25/100 tablet 1 every 4 hours PRN (as needed) limit 2 doses in 24 hours.</p> <p>A facility care plan for Resident #135, dated 5/10/12, indicated the problem</p>				

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	<p>area of resident has anxious complaints and health related complaints, asks frequent questions regarding Sinemet for Parkinson's disease, and resident wants to be woke up to receive medication. Approaches to the problem included, but were not limited to, administer medications as ordered.</p> <p>The Medication Administration Record (MAR) for Resident #135, for the month of July, 2012, indicated on 7/22/12, Resident #135 received the Sinemet ordered at 6:00 a.m., but did not receive the Stalevo ordered TID. The MAR also indicated no Sinemet PRN was given on 7/22/12. The nurse's medication notes on 7/22/12 indicated the Stalevo was not available in the facility.</p> <p>A Resident Progress Notes for Resident #135, dated 7/22/12, did not contain an entry addressing the Stalevo not available in the building or physician notification.</p> <p>LPN #11 was interviewed on 8/9/12 at 8:48 a.m. During the interview she indicated Resident #135 received both Sinemet and Stalevo for his Parkinson's disease. She also indicated the PRN Sinemet was usually given during the night shift</p>			

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	<p>when he would wake up from sleeping and was concerned his tremors would start. She further indicated she had never had to give him his PRN Sinemet since his Stalevo was always available in the facility.</p> <p>The Director of Nursing Services was interviewed on 8/9/12 at 2:55 p.m. During the interview she indicated Resident #135 did not receive his Stalevo TID or PRN Sinemet from the facility on 7/22/12. She also indicated she could not determine if staff should have provided the PRN Sinemet when the ordered Stalevo was not available.</p> <p>A facility Complaints/Grievances form for Resident #135, dated 7/23/12, indicated LPN #10 said his morning and afternoon doses of Stalevo were not available in the med cart on 7/22/12. The form also indicated Resident #135's girlfriend had his medication at home and gave it to him so he did not miss a dose. The form further indicated other nurses indicated the Stalevo was in the medication cart the entire time.</p> <p>A current facility policy "Medication Administration", dated 8/31/11 and provided by the Director of Nursing</p>			

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	<p>Services on 8/9/12 at 3:20 p.m., indicated "...distribute physician ordered medications to patients...document withheld, refused, or medications given at other than the scheduled time by circling initialed space and providing an explanation of the reverse side of MAR...notification of physician of withheld, refused, or medications given at other than scheduled times...."</p> <p>LPN #17 was interviewed on 8/10/12 at 11:20 a.m. During the interview she indicated if an ordered medication for a resident was not available in the facility, the EDK (emergency drug kit) was checked for the medication and if the medication was not in the EDK, the contractual pharmacy was notified. She also indicated the contractual pharmacy then contacted the local pharmacy to provide the medication. She further indicated if the local pharmacy did not provide the medication in a timely fashion, the physician was notified and the physician should always be notified if a medication was not available for the entire day.</p> <p>3.1-25(a) 3.1-25(o)</p>			

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F0431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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, record review, and interview, the facility failed to ensure a medication (Procrit) was</p>	F0431	<p>1. Resident #151 incurred no negative outcome as a result of administration of the non-refrigerated medication.</p>	09/10/2012			

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	<p>stored within the proper temperature controls(refrigerated) as required prior to administration.</p> <p>This affected 1 resident observed during medication pass. (Resident #151).</p> <p>Findings include:</p> <p>During observation of the medication pass with LPN #10, beginning at 9:20 a.m., on 8/8/12, the LPN was noted to be preparing medications for Resident #151.</p> <p>The LPN took a container with Procrit (a medication used for anemia) out of the medication drawer, prepared the oral medications, and proceeded into the resident's room. Observation of the label on the Procrit bottle indicated the medication was to be refrigerated.</p> <p>The LPN arranged the oral medications on the bedside table in the resident's room and separated them into order indicating this was how the resident liked to take them. The LPN then took 1 of the 2 single dose vials of Procrit from the container they were in, and drew the medication up into a syringe, and injected the medication into the resident's abdomen.</p> <p>At 11:35 a.m., on 8/8/12, and</p>		<p>2. All residents requiring Procrit have the potential to be affected; therefore this plan of correction applies to those residents.</p> <p>3. Licensed nursing staff has received in-service education relative to drug records, label/store drugs & biologicals, including but not limited to storage of medications within the proper temperature controls. A performance improvement tool has been developed to monitor proper storage of medications. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled working days, for 30 days. Any concerns will be immediately addressed with unit personnel. Thereafter, Director of Nursing, or designee, will monitor storage of medications randomly during the week prior to monthly PI committee meeting, on at least 3 days, for a minimum of 5 months. Any concerns will immediately be addressed with unit personnel.</p> <p>4. Director of nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>				

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	<p>accompanied by LPN #10, the container with the vial of Procrit was again observed in the medication cart. LPN #10 was interviewed at 11:35 a.m., on 8/8/12, and indicated the Procrit had not been refrigerated, and she would proceed to refrigerate it now.</p> <p>The Director of Nursing Services was interviewed at 2:10 p.m., on 8/8/12, and indicated LPN #10 had called the Pharmacist and the Physician and the Pharmacist had indicated the Procrit would not be effective due to not being refrigerated and would have to be given again on 8/9/12.</p> <p>Review of information from the facility pharmacy, provided by the Director of Nursing Services at 2:45 p.m., on 8/13/12, and regarding stability of the medication Procrit, indicated vials should be stored at 36 to 46 degrees Fahrenheit, and do not freeze or shake.</p> <p>The Director of Nursing Services was interviewed at 3:00 p.m. on 8/13/12, and indicated she had called the pharmacist who had indicated the information the pharmacy had sent was from a 2007 study of Procrit. She indicated the pharmacist had</p>			

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	recommended the medication be refrigerated. 3.1-25(m)			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F0441	1. Nurse #15 has been re-educated relative to proper	09/10/2012			

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	<p>cover clean clothing for residents during transport through hallways to prevent potential contamination. The facility also failed to ensure nursing staff disinfected a potentially contaminated glucometer after use during 1 of 2 observations of glucometer use. The facility also failed to ensure nursing staff washed hands during 1 of 5 observations of medication administration.</p> <p>Findings include:</p> <p>1. During an observation on B hall on 8/6/12 at 3:16 p.m., Laundress #9, was observed pushing a rack of clean clothes for residents through the hallway. The clothing cart was constructed from PVC pipe and had a pink cover surrounding the entire cart with velcro closures to keep the cover closed around the cart. The pink cover on the side of the clothing cart closest to the doors of the resident rooms had been placed on top of the laundry cart exposing the clean clothes. Laundry #9 was observed pushing the clothing cart of clean clothes from room to room without lowering the pink cover.</p> <p>2. During an observation on C hall on 8/9/12 at 5:00 p.m., Laundress #9,</p>		<p>procedure for disinfecting glucometers between residents and to necessity and importance of hand washing/hand hygiene during medication administration. Laundress #9 has been re-educated relative to proper procedure for transportation of resident's clean clothing through hallways. \</p> <p>2. All residents have the potential to be affected; therefore this plan of correction applies to all residents.</p> <p>3. Nursing center staff has received in-service education relative to infection control, prevent spread, linen, including but not limited to proper disinfection of glucometers, hand washing/hand hygiene during medication administration, and proper transportation of resident's clean clothing. A performance improvement tool has been developed to monitor proper infection control practices. SDC, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled working days, across all 3 shifts, for 30 days. Any concerns will be immediately addressed with responsible personnel. Thereafter, SDC, or designee, will monitor proper infection control practices randomly during the week prior to monthly PI committee meeting, on at least 3</p>	

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	<p>was observed pushing an open clothes rack of clean clothes for residents through the hallway. The rack was metal and there was no cover surrounding the rack. Laundry #9 was observed pushing the clothing cart of clean clothes from room to room without a cover.</p> <p>The Manager of Housekeeping and Laundry was interviewed on 8/10/12 at 8:45 a.m. During the interview he indicated laundry staff were to transport clean clothes in the covered rack in B Hall and were to cover the metal rack with a clean blanket or sheet in C Hall when distributing the clean clothes to the resident's rooms.</p> <p>A facility policy "Processing Resident Personal Clothing," dated 2/1/03 and provided by the Manager of Housekeeping and Laundry on 8/10/12 at 8:53 a.m., indicated "...no area of Laundry management is more critical to patient care...than the area of resident clothing...The rack of hung clothing...should be delivered daily..." The policy did not indicate the rack of clean clothing should be covered when delivered to resident rooms.</p> <p>3. On 8/8/2012 at 4:00 P.M., Nurse #15 was observed to use a glucometer (device used to measure blood sugar levels) to check the blood</p>		<p>days, for a minimum of 5 months. Any concerns will immediately be addressed with responsible staff.</p> <p>4. Director of nursing will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>				

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	<p>sugar for Resident #7. The nurse was observed to obtain a sample of blood on the glucometer test strip and insert the strip into the glucometer. After obtaining and recording the blood sugar levels and discarding the test strip, Nurse #15 was observed to briefly wipe the outside of the glucometer with a small alcohol wipe. When asked what she was using to disinfect the glucometer, Nurse #15 indicated she had used an alcohol wipe.</p> <p>The facility Director of Nursing (DON) was interviewed on 8/8/2012 at 5:00 P.M. During the interview, the DON indicated nursing staff were to disinfect glucometers after each use according to the manufacturer's recommendations.</p> <p>A policy provided by the DON on 8/8/12 at 5:15 P.M., entitled "Surestepflex Blood Glucose Monitoring System Calibration and Cleaning" and dated 10/31/2010, indicated "Clean the outside of the meter with a 10% bleach solution moistened wipes in-between each resident and as needed. Allow contact with bleach solution for 1-minute."</p> <p>4. On 8/8/2012 from 3:10 P.M. until</p>			

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	<p>4:25 P.M., Nurse #15 was continuously observed while administering medications to residents on the 100 hall on the B Wing.</p> <p>At 3:10 P.M., Nurse #15 was observed to prepare medication for Resident #157 at the medication cart in the hallway and then take the medication into the resident's room. She was observed to put on latex exam gloves and administer the medication to the resident through a G-tube (gastro-intestinal tube) and then remove the gloves and return to the medication cart. The nurse was not observed to wash her hands prior to putting on the gloves and was not observed to wash her hands or clean her hands with hand sanitizer after administering the medications and removing the gloves and leaving the room. Nurse #15 returned to the medication cart and was then observed to prepare an oral medication and a medication to be administered via a nebulizer (a device used to administer medicated breathing treatments) for Resident #127. The nurse was observed to enter the resident's room and administer the oral medication to the resident. The nurse was then observed to place the other</p>			

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	<p>medication into the nebulizer and place the face mask of the nebulizer onto the resident and turn on the nebulizer. The nurse was not observed to wash her hands or to clean her hands after administering the medications and leaving the room. The nurse was observed to return to the medication cart and prepare oral medication for Resident #33. The nurse entered the resident's room and indicated the resident was not in her room. The nurse walked to the dining room located on the C Wing to find the resident. The nurse did not locate the resident in the dining room and returned to the resident's room on the B Wing. Resident #33 was in her room at that time and Nurse #15 was observed to enter the room and administer the medications to the resident. The nurse was not observed to wash her hands or to clean her hands with hand sanitizer before or after administering the medications. The nurse was then observed to return to the medication cart to prepare oral medication for Resident #183. The nurse was observed to prepare the medication and enter the resident's room. The nurse was observed to administer the medication to Resident #183 and then return to the medication cart. The nurse was not</p>			

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	<p>observed to wash her hands or to use hand sanitizer after administering the medication and returning to the medication cart.</p> <p>The facility DON was interviewed on 8/8/2012 at 5:00 P.M. During the interview, the DON indicated nursing staff were to wash hands between each resident when administering medications.</p> <p>A facility policy provided by the DON on 8/8/2012 at 5:15 P.M., titled "Medication Administration" and dated 8/31/2011, indicated nursing staff were to wash hands prior to unlocking the medication cart and preparing medications and then once again prior to preparing the medications.</p> <p>The Staff Development Coordinator, Nurse #18, was interviewed on 8/13/2012 at 10:30 A.M. During the interview, Nurse #18 indicated staff were expected to wash hands before and after providing care for residents, including administering medications. Nurse #18 indicated staff could use a hand sanitizer in between residents if their hands did not become soiled with body fluids, but staff then had to wash their hands with soap and water hands after providing care for two</p>			

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	<p>residents in a row. Nurse #18 further indicated staff were to wash hands before putting on exam gloves and after removing them.</p> <p>3.1-18(l) 3.1-19(g)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 microwave ovens were clean in the pantry room of C wing and the dining area in the Memory Care Unit.</p> <p>Findings include:</p> <p>During observation of the Dining area, located on the Memory Care Unit at 8:56 a.m., on 8/13/12, and accompanied by the Dietary Manager, the microwave was observed on a counter next to the refrigerator. The inside of the microwave was scattered with dry food debris on all sides, and the top and bottom of the microwave.</p> <p>The Dietary Manager indicated the nursing staff on the unit were responsible for cleaning the microwave.</p> <p>During observation of the pantry room on C wing, at 9:10 a.m., on 8/13/12, and accompanied by RN#13, the inside of the microwave was observed to be splattered with dried food debris on all sides, the top and bottom of the</p>	F0465	<p>1. The microwave ovens were cleaned at the time of discovery during the survey.</p> <p>2. All residents have the potential to be affected; therefore this plan of correction applies to all residents.</p> <p>3. Nursing center staff has received in-service education relative to safe/functional/sanitary/comfortable environment, including but not limited to proper cleaning of microwave ovens. A performance improvement tool has been developed to monitor proper cleaning of microwave ovens. Executive Director, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled days of work, for 30 days. Any concerns will be immediately addressed with unit personnel. Thereafter, Executive Director, or designee, will monitor proper cleaning of microwave ovens randomly during the week prior to monthly PI committee meeting, on at least 3 days, for a minimum of 5 months. Any concerns will immediately be addressed with unit staff.</p>	09/10/2012	

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	<p>microwave. RN#13 indicated she did not know who was responsible to clean the microwave.</p> <p>The Director of Nursing Services was interviewed at 11:24 a.m., on 8/13/12, and indicated there was no written policy for microwave cleaning; however, the third shift CNAs were responsible for cleaning the microwaves.</p> <p>3.1-19(f)</p>		<p>4. Executive Director will review findings weekly and report findings to PI committee monthly for six months.</p> <p>5. Completion Date: September 10, 2012</p>		

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F9999	<p>3.1-14 PERSONNEL</p> <p>A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin</p>	F9999	<p>1. CNA #s 22 and 23 have received necessary PPD testing.</p> <p>1. An audit has been conducted of personnel files of all employees hired within the previous 90 days to identify any other employees requiring additional PPD testing with the same administered.</p> <p>1. SDC has been re-educated relative to personnel, including but not limited to PPD testing requirements for newly hired employees. A performance improvement tool has been developed to monitor new employee PPD testing. Director of Nursing, or designee, shall be responsible for completion of the Performance Improvement tool daily, on scheduled days of work, for 30 days. Any concerns will be immediately addressed with SDC. Thereafter, Director of Nursing, or designee, will monitor new employee PPD testing during the week prior to monthly PI committee meeting for new employees hired during the previous month, for a minimum of 5 months. Any concerns will immediately be addressed with the SDC.</p> <p>4. Director of nursing will review findings weekly and report findings to PI committee monthly for six months.</p>	09/10/2012			

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	<p>skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>These state rules were not met as evidenced by:</p> <p>Based on employee record review and interview, the facility failed to ensure 2 of 5 new employees reviewed received a second step Mantoux (tuberculin skin test) (CNA #22 and CNA #23).</p> <p>Finding includes:</p> <p>On 8/13/12 at 10:30 a.m., review of employee files indicated CNA #22 was hired on 6/6/12 and received a first step Mantoux test. There was no documentation in the employee's file that she had received a second step Mantoux.</p> <p>Review of CNA #23's personnel file indicated she was hired on 6/26/12 and received a first step Mantoux test. There was no documentation in the employee's file which indicated</p>		5. Completion Date: September 10, 2012		

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	<p>she had received a second step Mantoux.</p> <p>Interview with the Staff Development Coordinator on 8/13/12 at 11:30 a.m., indicated she was hired on 6/18/12. She indicated she did not know until last week about new employee Mantoux testing.</p> <p>On 8/13/12 at 2:00 p.m., review of the facility policy "Employee Health Program," dated 10/5/11, indicated the following:</p> <p>"Administer a baseline TB skin test (Mantoux test) to new employees and volunteers with more than 10-hours of patient contact each week.</p> <p>a. Administer the baseline TB skin test using the two-step method to employees not having a documented negative TB skin test result in the preceding 12 months. Do this to detect boosting phenomena that might be misinterpreted as a skin-test conversion."</p> <p>3.1-14(t)(1)</p>						