

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
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NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN46131
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F0000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00099434.</p> <p>Complaint IN00099434 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 14, 15, 16, 17, 18, and 21, 2011</p> <p>Facility number: 001127 Provider number: 155771 AIM number: 200247220</p> <p>Survey team: Leia Alley, RN, TC Marcy Smith, RN Patty Allen, BSW, (November 15, 16, 17, 18 and 21, 2011) Courtney Mujic, RN, (November 16, 17, and 18, 2011) Beth Kolasa, RN, (November 14, 15, 18 and 21, 2011) Barb Hughes, RN, (November 14, 15, 18 and 21, 2011) Karina Gates, BS, (November 14, 15, 18 and 21, 2011)</p> <p>Census bed type: SNF 19 NF 100</p>	F0000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiency herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiency cited has been corrected by the date certain.	

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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F0282 SS=E	<p>SNF/NF 10 NCC 32 Residential 156 Total 317</p> <p>Census payor type: Medicare 22 Medicaid 62 Other 233 Total 317</p> <p>Sample: 24 NCC sample : 5 Residential sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/29/11 by Jennie Bartelt, RN.</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. Based on record review and interview, the facility failed to ensure laboratory tests were performed in a timely manner and as</p>	F0282	The licensed nursing staff recognizes and understands the importance of performing laboratory tests in a timely	12/21/2011	

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	<p>ordered by the physician for 4 of 12 residents (Residents #124,#101, #23, and #43) reviewed for results of laboratory test results, in a total sample of 24.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #124 was reviewed on 11/15/11 at 9:45 a.m.</p> <p>The diagnosis for Resident #124 include but are not limited to renal failure, diabetes mellitus, hypertension, and hyperlipidema.</p> <p>In the November 2011 Physician Orders, there was an order for an A1C (glycosylated hemoglobin, blood test for average glucose levels), every 3 months. The order was dated 07/19/11 and the A1C was to be completed 10/19/11.</p> <p>In an interview with RN #5 on 11/15/11 at 11:30 a.m., she indicated that the lab was not completed and was not able to provide further explanation for the incomplete order.</p> <p>2. The clinical record for Resident #101 was reviewed on 11/18/11 at 10:00 a.m.</p> <p>The diagnoses for Resident #101 included, but were not limited to: CVA (cerebral vascular accident) and</p>		<p>manner as ordered by the physician. Continuing education on the importance of laboratory testing per physician order will improve nursing awareness to ensure laboratory test are completed timely. 1) Resident #124 was cited for not having an A1C laboratory test completed on 10/19/11 as ordered. Licensed nursing staff providing care for Resident #124 during that time frame was counseled in regards to ensuring laboratory tests are completed in a timely manner. 2) Resident #101 was cited for not having a CPK, AST, and CBC laboratory test completed as ordered. Licensed nursing staff providing care for Resident #101 during that time frame was counseled in regards to ensuring laboratory tests are completed in a timely manner. 3) Resident #43 was cited for not having an electrolytes, creatinine, and BUN laboratory test completed every two weeks as ordered. These laboratory tests were instead completed monthly. Licensed nursing staff providing care for Resident #43 during that time frame was counseled in regards to ensuring laboratory tests are completed in a timely manner. 4) Resident #23 was cited for not having a BMP laboratory test completed every three months as ordered, in that the next due date of October 2011 was not completed. Licensed nursing staff providing care for Resident</p>		

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	<p>hyperlipidemia.</p> <p>The November 2011 physician's recapitulation orders indicated fasting lipid, AST (aspartate transaminase, a lab test that may indicate liver damage), and CPK (test that measures creatine phosphokinase) labs to be drawn every six months due in March and September effective 6/10/08. It also indicated a CBC (complete blood count) lab to be drawn every six months due in January and July effective 6/16/09. No information could be found in the clinical record to indicate the fasting lipid, AST, and CPK were drawn in the month of September 2011 or the CBC was drawn in the month of July 2011.</p> <p>During interview with RN #5 on 11/18/11 at 10:35 a.m., she indicated the CPK lab was not drawn as ordered until 11/9/11 and there was no information to indicate the fasting lipid and AST were drawn in September 2011 or anytime thereafter. She also indicated there was no information to indicate the CBC lab was drawn in July 2011 or anytime thereafter. She indicated her expectation was for the fasting lipid, AST, and CPK labs to have been drawn in September 2011 as ordered by the physician and for the CBC lab to have been drawn in July 2011 as ordered by the</p>		<p>#23 during that time frame was counseled in regards to ensuring laboratory tests are completed in a timely manner. A) All Residents have the potential to be affected by laboratory tests not being completed as ordered. Monthly audits will be completed weekly for one month, then bi-weekly for one month, and then monthly thereafter. B) All units of the facility have had resident charts and physician orders reviewed to ensure the orders match each resident's monthly re-writes. These orders will be verified with the laboratory technician to ensure the orders match the current orders that she is utilizing. All laboratory tests will be placed on a master calendar on each unit that will be monitored by the Unit Secretary to ensure each resident of the facility has laboratory tests completed timely as ordered by each one's physician. The facility's Pharmacy Consultant will continue to monitor monthly to ensure laboratory tests are completed as per physician order. Each Unit Manager will monitor the completion of each resident's laboratory tests per physician orders when the monthly recaps are completed. C) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process when receiving a physician orders for laboratory testing is followed. This</p>				

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	<p>physician.</p> <p>3. The record of Resident #43 was reviewed on 11/16/11 at 8:50 a.m.</p> <p>Diagnoses for Resident #43 included, but were not limited to, high blood pressure, bipolar manic depression, hyponatremia and thrombocytopenia.</p> <p>A recapitulated physician's order for November 2011, with an original date of 7/2/11, indicated Resident #43 was to have a laboratory blood draw for electrolytes, creatinine and BUN (blood, urea and nitrogen) every 2 weeks.</p> <p>Review of lab results for Resident #43 indicated her lab had been drawn 11/11/11, 9/15/11, 8/15/11 and 7/14/11. The resident was hospitalized in October 2011.</p> <p>Further information regarding the labs not drawn as ordered every 2 weeks was requested from RN #4 on 11/16/11 at 3:00 p.m. On 11/17/11 at 10:50 a.m., RN #4 indicated the labs had not been drawn every 2 weeks as ordered. She indicated she had called the laboratory and they indicated their order was for the labs to be drawn monthly.</p> <p>4. The record of Resident #23 was</p>		<p>in-servicing will be completed by December 21, 2011. All newly hired nursing staff will receive the same education. D) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. Substantial compliance date: December 21, 2011.</p>		

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	<p>reviewed on 11/17/11 at 9:00 a.m.</p> <p>Diagnoses for Resident #23 included, but were not limited to, high blood pressure, peptic ulcer disease and dementia with behaviors.</p> <p>A recapitulated physician's order for November 2011, with an original date of 6/22/11, indicated Resident #23 was to have a BMP (basic metabolic panel) drawn every three months, with next draw due 10/11.</p> <p>Review of lab results for Resident #23 indicated a BMP was drawn 7/12/11. There were no other results found in the record for October, 2011.</p> <p>Further information was requested from RN #3 on 11/17/11 at 10:15 a.m. regarding BMP results for October, 2011. On 11/17/11 at 10:30 a.m. RN #3 indicated the lab was not drawn.</p> <p>During an interview with the Director of Nursing on 11/17/11 at 12:05 p.m., she indicated the pharmacist, nursing, and lab checks monthly to make sure labs are done as ordered. She indicated she did not know how Resident #23's October 2011 BMP was missed.</p> <p>3.1-35(g)(2)</p>				

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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure an assessment of a resident's pain before and after the administration of PRN (as needed) pain medications was conducted for 1 of 7 residents reviewed for receiving pain medication for pain control in a total sample of 24. (Resident #70)</p>	F0329	During the annual survey, the ISDH team identified that the facility was out of compliance with the regulation of F329. This was identified by the review of one resident out of seven residents reviewed who received PRN pain medication. This one resident lacked documentation: On three different occasions a pre and post assessment was not completed	12/21/2011

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	<p>Findings include:</p> <p>The clinical record for Resident #70 was reviewed on 11/18/11 at 11:30 a.m.</p> <p>The diagnoses for Resident #70 included, but were not limited to: debility and sick sinus S]syndrome.</p> <p>The October 2011 physician's recapitulation orders for Resident #70 indicated 1 mg of Dilaudid to be given by mouth every 4 hours PRN for pain.</p> <p>The October 2011 MAR (Medication Administration Record) for Resident #70 indicated Dilaudid was given on 10/21/11, 10/27/11, and 10/31/11. There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given.</p> <p>The November 2011 physician's recapitulation orders for Resident #70 indicated one 200 mg capsule of Ibuprofen to be given orally every 6 hours as needed for pain.</p> <p>The November 2011 MAR for Resident #70 indicated Ibuprofen was given on</p>		<p>when PRN pain medication was delivered per physician order. It is the policy and procedure of the facility to assess each resident prior to and following the delivery of any PRN medication. 1) Resident #70 received Dilaudid on 10/21/11, 10/27/11, and 10/31/11. Resident #70 also received Ibuprofen on 11/1/11, 11/5/11, 11/11/11. On each of the above dates a pre and post assessment could not be found as completed. Resident #70 was on the same unit in the facility during the dates listed above. The staff on this unit were educated and counseled regarding completion of a pre and post assessment prior to giving a PRN pain medication. A) All residents have the potential to be affected by not having a pre and post assessment completed with the delivery of a PRN pain medication. Monthly audits of the MAR will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process for giving a PRN medication is followed. This in-servicing will be completed by December 21, 2011. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further</p>		

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	<p>11/1/11, 11/5/11, and 11/11/11. There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given.</p> <p>During interview with RN #12 on 11/18/11 at 1:00 p.m., she indicated there was no information to indicate a preassessment or post assessment for pain was done on the above dates. She also indicated her expectation was for preassessments and post assessments for pain to have been done when PRN pain medication was administered to Resident #70 and for the assessments to be documented on the back of the MAR or in the nurse's notes.</p> <p>3.1-48(a)(6)</p>		<p>recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: December 21, 2011.</p>		

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F0371 SS=E	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure staff served bread in a sanitary way for 1 of 1 resident observed for assistance with eating buttered bread in the Advanced Alzheimer's Unit (Resident #23) and 15 of 20 residents whose bread was handled with bare hands in the Murphy Special Care Unit. The facility also failed to ensure foods on the steam table were held at or above 141 degrees Fahrenheit in the Cart Room. This deficient practice had the potential to affect 74 of 95 residents served food from the Cart Room Kitchen.</p> <p>Findings include:</p> <p>1. During a dining observation in the Advanced Alzheimer's Unit on 11/15/11 at 5:20 p.m. Certified Nursing Assistant (CNA) #1 was observed feeding Resident #23. The CNA held a small piece of bread between her ungloved thumb and</p>	F0371	<p>It is the practice of Franklin United Methodist Community to procure, store/prepare/serve food in a sanitary manner.</p> <p>Temperature logs, daily follow-up, quality assurance assessments and weekly dietician reports are consistently used and available for review which support positive policy goal outcomes. I. What corrective action will ensure final tray preparation, which may include buttering bread, ensures bare hands do not come in contact with ready to eat foods?:</p> <p>1. In-service and educate staff of regulations and in turn procedures to ensure acceptable outcomes. 2. Review of the Holding Foods during Preparation and Before Service Policy has been done. 3. Review of 410 IAC 7-24-187 potentially hazardous food; hot and cold holding of the Retail Food Establishment Sanitation Requirements. 4. An equipment inspection was done (hot food holding table was done and found no issues). 5. Any hot</p>	12/16/2011

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	<p>forefinger and placed the bread in Resident #23's mouth. At 5:24 p.m. on this date, the CNA held a small piece of bread in her bare hand and asked Resident #23 if she wanted it. At 5:27 p.m. the CNA again held a piece of bread between her ungloved thumb and forefinger and offered it to Resident #23.</p> <p>During an interview with the Dietary Director on 11/18/11 at 10:15 a.m. he indicated "My expectations would be that staff did not touch the residents' food with their bare hands."</p>		<p>food item found to be below 140 degrees will be taken back to the kitchen for reheating. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?: 1. All residents have the potential to be affected. III. What measures will be put into place or what systemic changes will be made that the deficient practice does not occur?: 1. In-service all dietary staff to keep foods stirred and covered while serving to ensure proper temperatures are kept on the hot food table from start to finish of meal service period. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 1. Daily follow-up and review of temperature log is done by dietary leadership team member to ensure proper temperatures are kept at the start and finish of meal service period. V. Date the systemic changes will be completed: December 16, 2011 The Facility received correspondence dated December 19, 2011 requesting additional explanation on one of the points outlined in this deficiency regarding food handling. The following explanation should clarify this matter. Please see below: During the annual survey, the</p>		

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			<p>ISDH surveyor identified the facility was out of compliance with the regulation of F371. It was stated in the 2567 the nursing and dietary staff handled the bread being served to residents with their bare hands.</p> <p>1) It is the practice of Franklin United Methodist Community to prepare/serve food in a sanitary manner. Daily follow-up; quality assurance assessments and weekly Dietician reports are consistently used and available for review which supports positive policy goal outcomes.</p> <p>A) Most residents have the potential to be affected by improper handling of food. Dietary and nursing staff recognizes and understands the importance of having proper food handling.</p> <p>B) All appropriate facility staff will be re-educated and receive on-going education on ensuring the process for handling food is followed. This in-servicing will be completed by December 21, 2011. All newly hired staff will receive the same education.</p> <p>C) Monthly audits of nursing units will be completed weekly for one month, then bi-weekly for one month, and then</p>		

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	<p>2. On 11/15/11 at 4:30 P.M., twenty residents were observed in the Murphy Special Care Unit dining area sitting at tables waiting for meals to be served. Food was brought into the unit at 4:30 and CNA #7 was observed pulling 1 tray at a time from enclosed serving cart, buttering bread with bare hands and serving to residents. At 5:15 P.M. CNA #6 started to assist by pulling trays and preparing food for serving. She was observed removing bread from a foil wrapping with bare hands, buttering it, cutting it into 2 pieces and serving. At 5:20 P.M., Dietary Aide #8 started to help with serving and was observed holding, cutting and buttering bread with bare hands and then touching the handles of the food cart to remove other trays. Fifteen residents were observed being served bread buttered by staff using bare hands.</p>		<p>monthly thereafter to ensure staff is not handling food being prepared or served to the residents improperly. D) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Dietary Director, Director of Nursing or designee will be responsible for assuring data presentation. E) Substantial compliance date: December 21, 2011.</p>		

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	<p>During an interview with CNA #6 and Dietary Aide #8 at 5:30 P.M. on 11/15/11, CNA #6 indicated that she touched the bread with her bare hands and that she had been trained not to touch ready to eat food with bare hands. Dietary Aide #8 indicated that she had also touched the bread with bare hands and had been trained not to use her bare hands when preparing ready to eat food.</p> <p>3. A tour of the kitchen was conducted with the Food Service Director on 11/14/11 at 10:42 a.m.</p> <p>On 11/14/11 at 11:20 a.m., during the middle of cart tray preparation in the Cart Room, Dietary Carts Employee #10 took the temperature of rice at 96 degrees Fahrenheit, spinach at 122 degrees Fahrenheit, chicken breast at 120 degrees Fahrenheit, and Dijon sauce at 122 degrees Fahrenheit.</p> <p>At this same time, an interview with Dietary Carts Employee #10, Dietary Carts Employee #9, and Dietary Carts Employee #11 was conducted. Dietary Carts Employee #10 looked at the temperature of the Dijon sauce and indicated the temperature was 122 degrees Fahrenheit. Dietary Carts Employee #9 looked at the temperature of the chicken breast and indicated the temperature was</p>				

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	<p>120 degrees Fahrenheit. Dietary Carts Employee #11 indicated they try to let foods leave the steam table at or above 140 degrees Fahrenheit.</p> <p>During interview with the Food Service Director on 11/14/11 at 12:30 p.m., he indicated he saw some things in the Cart Room that staff could have done differently to help maintain the temperatures of the food on the steam table like stir the foods.</p> <p>During interview with the Food Service Director on 11/21/11 at 9:45 a.m., he indicated the above foods were not done being served at 11:20 a.m. on 11/14/11 when these temperatures were taken.</p> <p>Review of the Holding Foods During Preparation and Before Service Policy, provided by the Food Service Director on 11/16/11 at 9:45 a.m., indicated hot foods must be maintained at a temperature of at least 140 degrees Fahrenheit.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure records were accurately maintained for documentation of accuchecks (a finger stick test measuring blood sugar) for 1 of 3 residents reviewed for documentation of accuchecks in a sample of 24. (Resident #56)</p> <p>Findings include:</p> <p>The record of Resident #56 was reviewed on 11/15/11 at 9:40 a.m.</p>	F0514	<p>It is the policy and procedure of the facility to ensure documentation in each resident's clinical record is current, complete and accurate for one of three residents reviewed that received daily accuchecks. Licensed nursing staff recognizes and understands the importance of having clinical documentation accurate with the correct time a procedure was completed. 1) Resident #56 was identified by the survey team as not having accuchecks that were completed, documented accurately, in that</p>	12/21/2011

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	<p>Diagnoses for Resident #56 included, but were not limited to, diabetes mellitus and dementia with delusions.</p> <p>A recapitulated physician's order for November, 2011, with an original order date of 7/20/11, indicated Resident #56 was supposed to receive accuchecks everyday before meals and at bedtime and the results of the accuchecks were supposed to be recorded. The accuchecks, on the physician's order, were scheduled for 7:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m.</p> <p>Review of a computerized "Blood Sugar Report" for October, 2011, received from RN #3 on 11/17/11 at 9:00 a.m. indicated the following:</p> <p>10/2/11: Blood sugars (BS) were documented for 2:13 p.m. and 6:38 p.m. RN #3 indicated these BS's were actually done at 11:00 a.m. and 4:00 p.m. respectively. She indicated the nurse forgot to change the time in the computer when she entered the BS's.</p> <p>10/5/11: BS's were documented for 10:10 a.m. and 6:46 p.m. RN#3 indicated these BS's were actually done at 7:00 a.m. and 4:00 p.m. respectively. She indicated the nurse forgot to change the time in the</p>		<p>when the licensed nursing staff member documented in the computer the results of the accucheck testing, she did not change the time of entry to correlate with the time the test was actually completed. This lack of accurate documenting was found on one of the nine units reviewed by the survey team. Therefore, it was found it was not a systems problem versus employee counseling. The employees on the unit of Resident #56 were educated and counseled regarding accurate charting when entering information into the computer system. A) All residents on the special care units have the potential to be affected by inaccurate documentation when entering the results of a test or procedure done prior to documentation. Monthly audits will be completed weekly for one month, then bi-weekly for one month, and then monthly thereafter.B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process of entering data on the electronic medical record is followed and the time of the actual treatment or procedure is entered correctly upon documenting. This in-servicing will be completed by December 21, 2011. All newly hired nursing staff will receive the same education.C) Collected data from the audit process will be reviewed</p>		

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	<p>computer when she entered the BS's.</p> <p>10/7/11: BS's were documented for 2:09:15 p.m., 2:09:39 p.m. and 6:11 p.m. RN #3 indicated these BS's were actually done at 7:00 a.m., 11:00 a.m. and 4:00 p.m. respectively. She indicated the nurse forgot to change the time in the computer when she entered the BS's.</p> <p>10/16/11: BS was documented for 10:44 a.m. RN #3 indicated this blood sugar was actually done at 7:00 a.m. She indicated the nurse forgot to change the time in the computer when she entered her BS.</p> <p>10/20/11: BS's were documented for 7:48 p.m. and 8:00 p.m. RN #3 indicated the first BS documented for 7:48 p.m. was actually done at 4:00 p.m. She indicated the nurse forgot to change the time in the computer when she entered the BS.</p> <p>10/28/11: BS was documented for 12:30 p.m. RN #3 indicated this BS was actually done at 7:00 a.m. She indicated the nurse forgot to change the time in the computer when she entered the BS.</p> <p>No other documentation was found in Resident #56's record indicated the correct times the above accuchecks were done.</p>		<p>monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation.D) Substantial compliance date: December 21, 2011.</p>		

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	<p>During an interview with the Director of Nursing on 11/17/11 at 11:35 a.m. she indicated she expected the nurses to document the actual time the BS's were done.</p> <p>Review of a facility policy, titled "Nursing Documentation Procedure and Guidelines," dated 6/7/5 and deemed current, indicated "...1. Each health care professional shall be responsible for making their own prompt, factual, concise and complete appropriate and legible entries...6. Late entries shall be discouraged, but may be entered. The entry must be dated on the date written and include the date and time that the original entry should have been made..."</p> <p>3.1-50(a)(2)</p>				

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R0000	The following state residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiency herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiency cited has been corrected by the date certain.		
R0301	(5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure 2 of 8 insulins had open dates, which is a professional standard of practice for medication administration. This had the potential to affect 2 of the 4 residents (Residents #9 and #21) receiving insulin from the medication cart.	R0301	During the annual survey the ISDH team identified on the residential unit that one of the medication carts contained two insulin vials that did not have an open date indicated on them. Licensed nursing staff recognizes and understands the importance of dating any medication that needs a date open documented.	12/21/2011	

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	<p>Findings include:</p> <p>The Back Hall Residential Floor #2 medication cart was observed with LPN #13 on 11/21/11 at 10:50 a.m.</p> <p>The Back Hall Residential Floor #2 medication cart contained Novolog 100 units/ml (milliter) for Resident #9. There was no open date on the medication. The same medication cart contained Novolog mix 70/30 10 ml vial, for Resident #21, and the medication had no open date.</p> <p>In an interview with LPN #13 on 11/21/11 at 10:55 a.m., she indicated there was no open date for either medication and could not provide an explanation for the missing dates.</p> <p>According to the website, "care.diabetesjournals.org/content/26/9/2665.full," accessed on 11/21/11 at 11:45 a.m., the website indicates, "After a vial of Novolog has been punctured, it may be kept for...up to 28 days...."</p>		<p>It is the policy and procedure of this facility to date insulin's once they are opened. A) Any residents with insulin have the potential to be affected by insulin vials not being dated upon opening. Monthly audits will be completed weekly for one month, then bi-weekly for one month and then monthly thereafter. B) All licensed nursing staff will be re-educated and receive on-going education on ensuring the process of dating insulin vials upon opening is followed. This in-servicing will be completed by December 21, 2011. All newly hired nursing staff will receive the same education. C) Collected data from the audit process will be reviewed monthly and reported to the Quality Assurance Committee for further recommendations. The Director of Nursing or designee will be responsible for assuring data presentation. D) Substantial compliance date: December 21, 2011.</p>		